Application for a Â§1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in section 1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The state has broad discretion to design its waiver program to address the needs of the waiverï¿½s target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid state plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A state has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

1. All references to “Plan of Care (POC)” have been updated to say, “Person Centered Service Plan (PCSP)”.

2. “Participant Experience Survey (PES)” has been updated to say, “Participant Survey”.

3. Updates and Changes to “Appendix A”:

“(A) Quality Improvement”
Section: “a. Methods for Discovery: Administrative Authority”, element “i”:
a. Added “Operating Agency” as a data source for intake packet reviews.
b. Updated frequency of data collection to monthly from quarterly (in addition to annually).

Section: “a”, element “ii”:
a. Updated section to say that providers will be reviewed every two years rather than annually and that reviews are to be conducted by ADSD Quality Assurance (QA). DHCFP has been removed as a provider reviewer. Provider review
results are submitted to DHCFP to be included in the Statewide Annual Review Report.

Section: “b”, element “i”:
a. Added language to establish monthly QA meetings between DHCFP and ADSD to discuss deficiencies and corrective strategies.

4. Updates and Changes to “Appendix B”:

“B6 Evaluation/Reevaluation of Level of Care”
Section “d”:
a. Updated language to clarify that 1 “Activities of Daily Living (ADL)” is needed for any “Instrumental Activities of Daily Living (IADL)” to be counted.

Section “f”:
a. Removed “Private and Public (ADSD Operations)” in reference to case management to say, “case management agencies”.

Quality Improvement – Level of Care Section “i” Sub-Assurances
a. Section “a” table updated. Removed “Continuously and Ongoing” from Data Aggregation and Analysis frequency.
b. Section “c” table updated. Added “100% Review”.

“B-7: Freedom of Choice”
Section “b”:
a. Updated to reflect electronic storage of recipient case files.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Nevada** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of section 1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Waiver for the Frail Elderly

C. Type of Request: renewal

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: NV.0152
Draft ID: NV.016.08.00

D. Type of Waiver *(select only one):*

Regular Waiver

E. Proposed Effective Date: (mm/dd/yy)

07/01/25

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: July 31, 2027). The time required to complete this information collection is estimated to average 163 hours per response for a new waiver application and 78 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR § 440.10**

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR § 440.160**

☒ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR § 440.40 and 42 CFR § 440.155**

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR § 440.140**

☐ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR § 440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

- ◉ **Not applicable**
- ○ **Applicable**

Check the applicable authority or authorities:

- ☐ **Services furnished under the provisions of section 1915(a)(1)(a) of the Act and described in Appendix I**
- ☐ **Waiver(s) authorized under section 1915(b) of the Act.**

Specify the section 1915(b) waiver program and indicate whether a section 1915(b) waiver application has been submitted or previously approved:

Specify the section 1915(b) authorities under which this program operates *(check each that applies):*

- ☐ **section 1915(b)(1) (mandated enrollment to managed care)**
- ☐ **section 1915(b)(2) (central broker)**
- ☐ **section 1915(b)(3) (employ cost savings to furnish additional services)**
- ☐ **section 1915(b)(4) (selective contracting/limit number of providers)**

- ☐ **A program operated under section 1932(a) of the Act.**

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

- ☐ **A program authorized under section 1915(i) of the Act.**
- ☐ **A program authorized under section 1915(j) of the Act.**
- ☐ **A program authorized under section 1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

- ☒ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Division of Health Care Financing and Policy (DHCFP) currently administers the 1915(c) Home and Community Based Services (HCBS) Waiver for the Frail Elderly (FE). The provision of waiver services is based on the identified needs of the waiver recipient. Nevada is committed to the goal of providing the elderly with the opportunity to remain in a community setting in lieu of institutionalization, with the ultimate goals of self-sufficiency and independence.

Aging and Disability Services Division (ADSD) operates the waiver, which includes data collection for eligibility verification and evaluation of Nursing Facility (NF) Level of Care (LOC). The DHCFP exercises administrative authority over the operation of the waiver and issues policies, rules, and regulations related to the waiver.

The purpose of this waiver is to offer the option of HCBS as an alternative to nursing facility care. Access to the services available in the waiver is voluntary and no individual is required to leave a nursing facility. The target population are individuals who are age 65 and older, has a need for at least one (1) waiver service, meet a NF LOC and financial eligibility.

Eligible applicants may be placed from an institution, another waiver program, or the community. An evaluation will be made to support that there is a reasonable indication that a recipient would require imminent placement in a nursing facility or hospital without home and community based services in place, the cost of which would be reimbursed under the approved waiver.

The following services are included in this waiver: Case Management, Homemaker, Respite, Chore, Home Delivered Meals, Personal Emergency Response Systems, Adult Companion Care, Adult Day Care, and Augmented Personal Care. Services will be provided in accordance with this waiver and by qualified Medicaid providers who have enrolled through DHCFP's fiscal agent.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the quality improvement strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in section 1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of section 1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ○ **Not Applicable**
- ◉ **No**
- ○ **Yes**

C. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in section 1902(a)(1) of the Act *(select one)*:

- ◉ **No**
- ○ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR § 441.302, the state provides the following assurances to CMS:

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to section 1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the

Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR § 441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR § 441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR § 441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR § 431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of section 1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR Part 433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. If a provider certifies that a particular legally liable third-party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR Part 431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR § 431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the quality improvement strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the state of the state's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Coulombe

First Name: Kirsten

Title: Chief, Long Term Services and Supports

Agency: Division of Health Care Financing and Policy

Address: 9850 Double R Blvd, STE 200

Address 2:

City: Reno

State: Nevada

Zip: 89521

Phone: (775) 684-3747 **Ext:** ☐ **TTY**

Fax: (775) 687-8724

E-mail: Kirsten.coulombe@dhcfp.nv.gov

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Wren

First Name: Crystal

Title: Social Services Chief

Agency: Aging and Disability Services Division

Address: 1550 E. College Parkway, Carson City, NV. 89706

Address 2:

City: Carson City

State: Nevada

Zip:

89706

Phone:

(775) 687-0969 **Ext:** ☐ **TTY**

Fax:

(775) 687-0581

E-mail:

cwren@adsd.nv.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under section 1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Nevada**

Zip:

Phone:

Ext: ☐ TTY

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Waiver Services Rate Methodology:
The rate methodology for Medicaid Waiver Services is outlined in the Waiver. All Waiver Amendments regarding Rate Methodology creation or changes are subject to 30-day Public Input to allow feedback/comments from the public/stakeholders. During the 30-day public comment period, the state also conducts Public Workshops for added transparency. The DHCFP solicits public comments in a variety of ways: private meetings with stakeholders, public workshop, collaboration with other state divisions when necessary and/or public hearings.

Administrative activities and direct service activities are separated as follows:

Administrative Case Management Activities:

1. All activities completed by the Intake Specialist prior to Waiver Enrollment
2. Facilitating Medicaid eligibility, which may include assistance with the Medical Assistance for the Aged, Blind and Disabled (MAABD) application and obtaining documents required for eligibility determination.
3. LOC review and approval by Case Management Provider (Operations Unit).
4. Travel
5. Communication and/or data collection provided by the case manager to the quality assurance unit in response to the results of a Participant Survey finding.
6. Request of Notice of Decision (NOD) when a negative action is taken (Denial, suspension, termination, and reduction of services.)
7. Any action the case manager takes for a recipient who is no longer in an active status due to a negative action being determined. This includes attendance for an Administrative Fair Hearing/Appeal with the DHCFP.
8. General Administrative tasks (scheduling of visits, voicemails, email communication with DHCFP, scanning and uploading documents, mailing provider lists and/or resources to recipient, telephoning providers for general availability, outreach activities for solicitation, etc.)

Direct Case Management Activities:

1. Completion of the Social Health Assessment (SHA), and LOC with the recipient (Annual redetermination of eligibility and any change of condition)
Note: If the case manager is unable to complete the SHA while meeting directly with the Waiver recipient, and they are completing the SHA when they gain access to the document, the case manager may bill for time taken to summarize their findings and create and complete the SHA, they may not, however, bill for time taken to repeat the information gathered in person and transfer this to the SHA form.
2. PCSP Development and follow-up for initiation
3. PCSP monitoring/follow-up (includes provider changes, a change in services/delivery, change in condition resulting in an amended PCSP, etc.)
4. Any activity related to the Prior Authorization (PA) request, approval and/or follow-up.
5. Any mandated reporting activity (APS, LTCO, HCQC, Law Enforcement, etc.).
6. Resource navigation, facilitation, coordination and support intended to aid, navigate and connect with Waiver and Community resources.
Note: Understanding the case manager may not always be with the recipient while performing resource navigation activities is considered an example and not all inclusive. The case manager may bill for case management activities for performing resource navigation, facilitation, and coordination of care.
7. Care Conference (collaboration and involvement in discharge planning from a LTC setting; interdisciplinary meetings; collaboration with other entities on shared cases; coordination of multiple services and/or providers based on the identified needs in the SHA;
8. Monitoring the overall provision of waiver services, in an effort to protect the safety and health of the recipient and to determine that the PCSP goals are being met
9. Monitoring and documenting the quality of care through contacts with recipients
10. Ensuring that the recipient retains freedom of choice in the provision of services
11. Notifying all affected providers of changes in the recipient's medical status, service needs, address, and location, or of changes of the status of LRI or Designated Representative

12.Notifying all affected providers of any unusual occurrence or change in status of a waiver recipient
13.Notifying all affected providers of any recipient complaints regarding delivery of service or specific provider staff
14.Notifying all affected providers if a recipient requests a change in the provider staff or provider agency
15.Any adverse actions taken to an eligible/actively enrolled Waiver recipient resulting in suspensions, terminations and/or reductions in services.
Case Managers must provide recipients with the appropriate amount of case management services necessary to ensure the recipient is safe and receives sufficient services. Case management is an as needed service. Case managers must, at a minimum, have an annual face-to-face visit and ongoing contact that is sufficient to meet the needs of the recipient. The amount of case management services must be adequately documented and substantiated by the case manager's notes.
* Any Recipient who is in an active “suspended” status is not eligible for billable services. All services rendered are considered Administrative while in suspended status.

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

○ **The waiver is operated by the state Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

○ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

◉ **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

Aging and Disability Services Division (ADSD)

In accordance with 42 CFR § 431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the state Medicaid agency. Thus this section does not need to be completed.

b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

DHCFP has an Interlocal Agreement/Contract with ADSD which outlines the responsibilities for both DHCFP and ADSD with respect to Medicaid 1915(c) HCBS Waivers.

The contract indicates DHCFP is responsible for the administration of the 1915(c) Medicaid Waivers: Frail Elderly (FE), Individuals with Intellectual and Developmental Disabilities (ID), Physically Disabled (PD) and Structured Family Caregiving (SFCG). ADSD is responsible for the operation of the HCBS Waivers. The contract is renewed every five (5) years and any modification/amendment (if necessary) to the contract must be mutually agreed upon by both parties. The contract is reviewed when the needs arise such as updating waiver policies, Waiver renewal or amendment. Termination of the contract will require DHCFP approval as well as a plan for the continuity of DHCFP oversight and ADSD operational functions.

Under the Interlocal Contract, ADSD agrees to perform the following operational functions for the HCBS waivers:

o Performs initial Level of Care (LOC) Evaluation for admission onto the waiver program.
o Reviews and approves LOC re-evaluation conducted by case management agencies.
o Referrals, interagency coordination, and monitoring of Medicaid covered waiver services.
o Quality Assurance reviews Serious Occurrence Reports (SOR) to ensure relevant follow-up activities are completed appropriately; conduct recipient's satisfaction survey of providers and waiver services, and training and
education of staff.
o Complete waiver enrolled provider compliance as outlined in Appendix C.
o Cooperate with DHCFP's annual review process and any corrective actions.
o Participate in DHCFP monthly quality improvement and quarterly consistency meetings as required.
o Conduct training to waiver providers as necessary.
o Manage waiver enrollment including waitlist and slot allocation.
o In support of the fair hearing process, assist and cooperate in defense of the decision, and provide written material and testimony as requested by DHCFP hearings unit staff and/or the assigned Deputy Attorney General.
o In the event a financial review result indicates that ADSD obtained or was paid incorrectly by funds from Medicaid for activities provided under the agreement, ADSD shall repay the funds to Medicaid.

To ensure the operating agency is performing in accordance with waiver guidelines, DHCFP/SMA conducts monthly reviews of intake packets completed by the operations intake unit to ensure individuals' entrance to the waiver program are in accordance with waiver requirements; and annually, as part of DHCFP case file reviews of LOC re-evaluations to ensure the recipients continue to meet NF LOC criteria as reviewed and approved by the operating agency prior to case managers authorizing direct waiver services.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

The fiscal agent is the Quality Improvement Organization (QIO)-like Vendor and operates as the utilization and quality control for all DHCFP Medicaid programs and is contracted by DHCFP. For the purpose of this FE Waiver renewal and for consistency, the QIO-like Vendor will be referred to as the fiscal agent.

DHCFP has established program policies and procedure for all provider types – Medicaid Manual Service (MSM) Chapter 100 Medicaid Program. In addition, each provider type and specialty established additional policy and procedures. The fiscal agent implement those policies and procedures when enrolling provider applicants. Provider applicants submit application electronically through the fiscal agent's website; enrollment checklist is available on the website as well for instruction and required documents. All provider applicants are processed according to each provider type and specialty requirements.

Provider applicants submit an application electronically through the fiscal agent's website. Enrollment checklists, detailing instruction for enrollment and all required documents are available on the fiscal agent's website as well. All provider applicants are processed according to the specific provider type and any specialty requirements.

The DHCFP Provider Enrollment Unit monitors and works closely with the fiscal agent. For example, when processing provider application (PT 48) and additional clarification pertaining to policy and approval is required, the provider enrollment unit will consult with the DHCFP Long Term Services and Supports (LTSS) Waiver Unit.

The fiscal agent's other responsibilities: claims processing, Medicaid Management Information Systems (MMIS) Interchange updates or fixing system errors, assists providers with claims denials, disseminating policy updates/changes to providers via web announcement posted on their website, reviews and approves authorization requests for several procedure/service codes requiring prior authorizations including pharmacy related requests, and prepares a monthly report of all provider enrollments by provider type for DHCFP review. Certain Medicaid State Plan Option programs such as State Plan Personal Care Services (PCS), the fiscal agent assess/re-assess and approves Medicaid recipients for the PCS program.

NOTE: For prior authorizations, waiver services approved by Public Case Managers are entered into the MMIS by ADSD; waiver services approved by Private Case Managers are reviewed and entered into MMIS by DHCFP LTSS Unit.

○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

◉ **Not applicable**

○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the state and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or

the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The DHCFP is responsible for assessing the performance of the fiscal agent providers.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

DHCFP is responsible for fiscal agent monitoring. The fiscal agent provides a series of reports to DHCFP on a monthly basis using a system called Electronic Document Management System (EDMS). These reports include provider enrollment, claims data, and PA data.

In addition, individual units receive quarterly programmatic information directly from the fiscal agent.

Due to the complexity of waiver reporting, the fiscal agent provides an annual report on waiver utilization which includes:

- Unduplicated count
- Medicaid eligibility code
- Primary diagnosis
- Age
- Total expenditures for program
- Total expenditures by service
- Total state plan expenditures for waiver recipients
- Service utilization by recipient
- Expenditures by recipient

The fiscal agent is required to submit Key Performance Measures (KPM) on an ongoing basis to the DHCFP Information Systems Project Management Office who is responsible for overseeing the contract with the fiscal agent. There are other units within DHCFP who monitor the fiscal agent such as Provider Enrollment for enrollment and Fiscal Integrity for claims.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR § 431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.* Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a

government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	☒	☒	☐
Waiver enrollment managed against approved limits	☒	☒	☐
Waiver expenditures managed against approved levels	☒	☐	☐
Level of care waiver eligibility evaluation	☒	☒	☐
Review of Participant service plans	☒	☐	☐
Prior authorization of waiver services	☒	☐	☐
Utilization management	☒	☐	☐
Qualified provider enrollment	☒	☐	☒
Execution of Medicaid provider agreements	☒	☐	☒
Establishment of a statewide rate methodology	☒	☐	☐
Rules, policies, procedures and information development governing the waiver program	☒	☒	☐
Quality assurance and quality improvement activities	☒	☒	☐

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which

each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of recipients who were enrolled according to waiver and/or state policy. N: Number of recipients enrolled according to waiver and/or state policy. D: Number of recipient packets reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☒ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level and +/- 5% margin of error.
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of providers who have executed Medicaid agreements prior to providing services to waiver recipients. N: Total number of providers who have executed Medicaid agreements. D: Total number of providers reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of Medicaid expenditures of waiver recipients which are demonstrated and validated with the cost neutrality formula and compared to nursing facility costs of care. N: Total expenditures of waiver services provided to waiver recipients. D: Total expenditures of nursing facility care.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data	**Frequency of data**	**Sampling Approach***(check*

collection/generation*(check each that applies):*	**collection/generation***(check each that applies):*	*each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The DHCFP Hearings Unit is responsible for all Medicaid applicants/recipients appeals; works closely with and communicates with the specific Medicaid Program Specialist and other responsible state staff who made an adverse decision. The Hearings Unit also monitors and tracks hearings and appeals for waiver services as well as all Hearing Preparation Meetings (HPM), Fair Hearings and outcomes. A report is available upon request.

Nevada MSM Chapter 100 is located on the DHCFP website and outlines provider requirements and administrative sanctions. DHCFP has a Provider Support Unit that tracks providers who are in sanction periods.

The DHCFP Quality Assurance (QA) Unit conducts annual programmatic and financial reviews of this waiver which is structured as a look back review of delegated functions. DHCFP QA has the ability to break out the review findings by geographical office or Statewide, in order to identify trends that may be applicable to a specific regional office, or generalized program issues.

The State strives for a sample size producing a probability of 95% and a confidence level of 5%. The State accomplishes this in the following ways:

A 95/5 review sample is completed by combining Case Management Case File reviews with annual DHCFP QA reviews, utilizing the same review tool.

A 95/5 review sample of participant satisfaction is completed by DHCFP and ADSD QA with recipients or their representatives using the Participant Survey tool.

A 95/10 sample of recipient financials is completed annually by DHCFP QA staff. The state is unable to complete a 95/5 sample of financials due to lack of resources; however, there are other reviews completed by Payment Error Rate Measurement (PERM), Fiscal Integrity, and the DHCFP Surveillance Utilization Unit that cover waiver financials.

95/5 sample of providers are reviewed every two years for compliance with provider requirements by ADSD QA. ADSD QA performs a combination of annual on-site and desk audit reviews of enrolled Waiver providers. Provider review results are then submitted to DHCFP QA to be included in the Statewide Annual Review Report.

During this review, the provider qualifications, employee files, training, and recipient files are reviewed. A maximum of 5 (five) employee files and a maximum of 5 (five) recipient files are reviewed. If a facility has less than 5 (five) recipients/caregivers, then review is completed at 100%. If the facility has more than 5 (five) each, a random sample of 5 (five) is pulled. The sample size of 5 (five) recipients/caregivers is determined by the state licensure agency, Health Care Quality and Compliance (HCQC). If appropriate, training is provided to include, Serious Occurrence Reporting, required form completion, and Activities of Daily Living (ADL) Log. Materials are given to the provider as necessary. ADSD QA maintains a spreadsheet of trainings provided which is reviewed on an ongoing basis. If there are any trends discovered, they are discussed at the monthly Quality Improvement (QI) meetings. Follow up visits by designated QA staff is completed when applicable. Providers can also request additional training on topics relevant to the Waiver.

DHCFP QA completes a management report of the annual review which is prepared and distributed as applicable to include the review findings listed above. An important goal of the annual review is to address and document broad issues and outcome measures, incorporating methods and criteria for prioritizing findings, and to improve documentation of remediation efforts and successes. The priority for these improvements is balanced by available staff and other necessary resources.

This annual report is used to identify any problems or issues with the Waiver, to include training for Waiver providers, system issues, or policy clarifications that both DHCFP and ADSD work to resolve.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Deficiencies are remediated through corrective strategies discussed in the quality improvement meetings to assure coordination of processes and are based on findings from the annual review. ADSD and DHCFP QA teams are responsible for monitoring progress based on established timelines and for reporting progress to DHCFP Long Term Services and Supports (LTSS).

DHCFP holds monthly QA meetings with ADSD Operating Unit to discuss any deficiencies found from administrative reviews i.e. intake and initial LOC evaluation, and case file reviews. Additionally, this meeting serves as a communication tool to discuss corrective strategies and/or education to ADSD Operations Unit, if applicable.

As part of quality improvement, DHCFP also holds scheduled quarterly meetings with Case Management Provider Agencies, as applicable, to discuss and offer suggestions to resolve identified trends and problems. Issues are prioritized and incorporated into a priority spreadsheet, and monitored, until resolution occurs.

ADSD Operations staff participate in the review and revision of the Waiver Application amendment/renewal, and MSM policy updates to provide operational perspective.

DHCFP has a contractual agreement with the fiscal agent to enroll qualified providers. The contract identifies the responsibilities of the fiscal agent. The fiscal agent is required to enroll only qualified providers and prepare a monthly report by provider type on enrolled providers and providers who did not meet qualifications. DHCFP staff reviews these reports on an ongoing basis.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR § 441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target Sub Group	Minimum Age			Maximum Age			
						Maximum Age Limit			No Maximum Age Limit
☒ Aged or Disabled, or Both - General									
	☒	Aged		65					☒
	☐	Disabled (Physical)							
	☐	Disabled (Other)							
☐ Aged or Disabled, or Both - Specific Recognized Subgroups									
	☐	Brain Injury							☐
	☐	HIV/AIDS							☐
	☐	Medically Fragile							☐
	☐	Technology Dependent							☐
☐ Intellectual Disability or Developmental Disability, or Both									
	☐	Autism							☐
	☐	Developmental Disability							☐
	☐	Intellectual Disability							☐
☐ Mental Illness									
	☐	Mental Illness							☐
	☐	Serious Emotional Disturbance							

b. Additional Criteria. The state further specifies its target group(s) as follows:

1. Individuals may be placed from a nursing facility, an acute care hospital, another Home and Community Based Waiver, or the community.

2. Individuals who, but for provision of services, would require a Nursing Facility Level of Care that would meet imminent placement in a nursing facility within 30 days.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

◉ **Not applicable. There is no maximum age limit**

○ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- (●) **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c*.
- ( ) **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c*.

  The limit specified by the state is *(select one)*

  - ( ) **A level higher than 100% of the institutional average.**

    Specify the percentage:

  - ( ) **Other**

    Specify:

- ( ) **Institutional Cost Limit.** Pursuant to 42 CFR § 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ( ) **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

  The cost limit specified by the state is *(select one)*:

  - ( ) **The following dollar amount:**

    Specify dollar amount:

    The dollar amount *(select one)*

○ **Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

○ **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**

○ **The following percentage that is less than 100% of the institutional average:**

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	4108
Year 2	4419
Year 3	4663
Year 4	4875
Year 5	5057

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)* :

- ○ **The state does not limit the number of participants that it serves at any point in time during a waiver year.**
- ◉ **The state limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	4208
Year 2	4519
Year 3	4763
Year 4	4975
Year 5	5157

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The state *(select one)*:

- ◉ **Not applicable. The state does not reserve capacity.**
- ○ **The state reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- (●) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

When slots are available under the Waiver, all applicants are placed into intake processing in the order in which their applications are received.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. 1. State Classification. The state is a *(select one)*:

- ( ) **Section 1634 State**
- (●) **SSI Criteria State**
- ( ) **209(b) State**

2. Miller Trust State.

Indicate whether the state is a Miller Trust State *(select one)*:

- ( ) **No**
- (●) **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR § 435.217)

☐ **Parents and Other Caretaker Relatives (42 CFR § 435.110)**

☐ **Pregnant Women (42 CFR § 435.116)**

☐ **Infants and Children under Age 19 (42 CFR § 435.118)**

☒ **SSI recipients**

☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR § 435.121**

☐ **Optional state supplement recipients**

☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

○ **100% of the Federal poverty level (FPL)**

○ **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in section 1902(a)(10)(A)(ii)(XIII)) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in section 1902(a)(10)(A)(ii)(XV) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in section 1902(a)(10)(A)(ii)(XVI) of the Act)**

☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in section 1902(e)(3) of the Act)**

☐ **Medically needy in 209(b) States (42 CFR § 435.330)**

☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR § 435.320, § 435.322 and § 435.324)**

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Special home and community-based waiver group under 42 CFR § 435.217) Note: When the special home and community-based waiver group under 42 CFR § 435.217 is included, Appendix B-5 must be completed

○ **No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR § 435.217.** *Appendix B-5 is not submitted.*

◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR § 435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR § 435.217**

◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR § 435.217**

Check each that applies:

☒ **A special income level equal to:**

Select one:

- (●) **300% of the SSI Federal Benefit Rate (FBR)**
- ( ) **A percentage of FBR, which is lower than 300% (42 CFR § 435.236)**

  Specify percentage: [ ]
- ( ) **A dollar amount which is lower than 300%.**

  Specify dollar amount: [ ]

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR § 435.121)**

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR § 435.320, § 435.322 and § 435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR § 435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

- ( ) **100% of FPL**
- ( ) **% of FPL, which is lower than 100%.**

  Specify percentage amount: [ ]

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR § 441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR § 435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR § 435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR § 435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR § 435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under section 1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under section 1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or section 1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time period after September 30, 2027 (or other date as required by law).

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law) (select one).

- (●) **Spousal impoverishment rules under section 1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

- (●) **Use spousal post-eligibility rules under section 1924 of the Act.**
  (Complete Item B-5-b (SSI State) and Item B-5-d)
- ( ) **Use regular post-eligibility rules under 42 CFR § 435.726 (Section 1634 State/SSI Criteria State) or under § 435.735 (209b State)**
  (Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

( ) **Spousal impoverishment rules under section 1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

b. Regular Post-Eligibility Treatment of Income: Section 1634 State and SSI Criteria State after September 30, 2027 (or other date as required by law).

The state uses the post-eligibility rules at 42 CFR § 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in ?1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

( ) **The following standard included under the state plan**

Select one:

- ( ) **SSI standard**
- ( ) **Optional state supplement standard**
- ( ) **Medically needy income standard**
- ( ) **The special income level for institutionalized persons**

(*select one*):

- ( ) **300% of the SSI Federal Benefit Rate (FBR)**
- ( ) **A percentage of the FBR, which is less than 300%**

  Specify the percentage: [ ]
- ( ) **A dollar amount which is less than 300%.**

  Specify dollar amount: [ ]

( ) **A percentage of the Federal poverty level**

Specify percentage: [ ]

( ) **Other standard included under the state plan**

Specify:

[ ]

○ **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The following formula is used to determine the needs allowance:**

Specify:

◉ **Other**

Specify:

The maintenance needs allowance is equal to the individuals total income as determined under the post-eligibility process which includes income that is placed in a Miller Trust.

ii. Allowance for the spouse only (*select one*):

◉ **Not Applicable**

○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in section 1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

◉ **Not Applicable (see instructions)**

○ **AFDC need standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically

needy income standard established under 42 CFR § 435.811 for a family of the same size. If this amount

changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

○ **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR § 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

◉ **Not Applicable (see instructions)** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

○ **The state does not establish reasonable limits.**

○ **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

c. Regular Post-Eligibility Treatment of Income: 209(b) State or after September 30, 2027 (or other date as required by law).

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules after September 30, 2027 (or other date as required by law)

The state uses the post-eligibility rules of section 1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines

the individual's eligibility under section 1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ○ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

  Specify percentage:
- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised
- ○ **The following formula is used to determine the needs allowance:**

  Specify formula:
- ◉ **Other**

  Specify:

  The maintenance needs allowance is equal to the individuals total income as determined under the post-eligibility process which includes income that is placed in a Miller Trust.

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR § 435.726 or 42 CFR § 435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

  Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR § 435.726 or 42 CFR § 435.735:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

◉ **Not Applicable (see instructions)** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

○ **The state does not establish reasonable limits.**

○ **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

e. Regular Post-Eligibility Treatment of Income: Section 1634 State or SSI Criteria State – January 1, 2014 through September 30, 2027 (or other date as required by law).

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

f. Regular Post-Eligibility Treatment of Income: 209(b) State ? January 1, 2014 through September 30, 2027 (or other date as required by law).

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules – January 1, 2014 through September 30, 2027 (or other date as required by law).

The state uses the post-eligibility rules of section 1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR § 441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the

reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The state requires (select one):

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- ( ) **Directly by the Medicaid agency**
- (●) **By the operating agency specified in Appendix A**
- ( ) **By an entity under contract with the Medicaid agency.**

Specify the entity:

- ( ) **Other**

Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR § 441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Individuals performing initial evaluation must have the following educational or professional qualifications: licensed as a Social Worker by the State of Nevada Board of Examiners for Social Workers, licensed as a Registered Nurse by the State of Nevada Board of Nursing, or have a professional license or certificate in a medical specialty applicable to the assignment; OR have at minimum a Bachelor's degree from an accredited college or university in social work, gerontology, counseling, nursing, psychology, human growth and development, special education, sociology, criminal justice or a closely related social science or human services field. One year of professional experience providing case management services in a social or health related field is preferred; or have an equivalent combination of education and experience.

Additional criteria:
* Has a valid driver's license to enable home visits.
* Follows Health Insurance Portability and Accountability Act (HIPAA) requirements.
* FBI Criminal History Background check.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency

(if applicable), including the instrument/tool utilized.

The name of the LOC tool is: NEVADA MEDICAID LEVEL OF CARE (LOC). This tool is used for all programs requiring determination of nursing facility level of care.

The Level of Care Tool consists of five categories which include: ability to self-administer medication, treatments and special needs, activities of daily living, need for supervision, and instrumental activities of daily living.

The total numeric score from the assessment tool determines whether an applicant meets nursing facility LOC. There are 13 total functional deficits identified on the Level of Care Assessment Tool. An eligible recipient or pending applicant must meet at least 3 deficits out of the 13 possible.

The five categories are broken down as follows:

Ability to self-administer medication: the inability to safely administer one's own medication counts as one functional deficit - (1);

Treatments and special needs: may include suctioning, ventilator dependent, feeding tube, wound care, glucose monitoring, IV lines, oxygen dependent, and pediatric specialty care among others. Treatments or conditions that an individual performs as self-care aren't included as a functional deficit. A recipient/applicant is only required to have one treatment or special need for this category to be counted - (1);

Activities of daily living: a total of eight functional deficits are possible in the areas of bathing, dressing, grooming, eating, mobility, transferring, ambulation, and continence - (8)

In this category, there are four (4) identifiable levels of assistance. 1) Independent (I) which means the recipient can independently perform this activity or requires no assistance to perform the activity with use of an adaptive device. 2) Supervision (S) which means to the recipient's safety, a caregiver must oversee this activity. 3) Assistance (A) which means the recipient requires help. 4) Dependent (D) which means the recipient is totally dependent on the caregivers to complete this activity for him or her. If any of the areas is determined S, A or D, it counts as a deficit. An area determined as an "I" does not count as a deficit;

Need for supervision: a total of one functional deficit is possible for the areas of wandering, resists care, behavior problem, safety risk, socially inappropriate, verbally abusive, and physically abusive - (1);

Instrumental activities of daily living (IADLs) – (2):

Meal Preparation – 1 point

Homemaking Services – 1 point

There must be at least 1 ADL need in order for the IADL need(s) to count.

Total Possible - 13

Total Needed to Meet Level of Care - 3

e. Level of Care Instrument(s). Per 42 CFR § 441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

◉ **The same instrument is used in determining the level of care for the waiver and for institutional care under the state plan.**

○ **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR § 441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The LOC assessment tool is used to screen, assess, and reassess that a NF LOC to establish eligibility criteria for the waiver. Initial LOC Assessments are completed and reimbursed as an administrative function by the Operating Agency qualified staff. Reassessments are conducted by the Case Management provider and are completed annually, or if there is a significant change in condition or circumstances that may affect eligibility. Intake duties are separate and distinct from case management services covered in the waiver.

When a referral is received and assigned, the Operating Agency will make contact with the applicant/designated representative/LRI within 15 working days of receipt of the completed referral.

The Operating Agency will assign an Intake Specialist to assess, determine and approve an applicant's LOC.
The LOC assessment will determine the applicant's eligibility for waiver services and placement on the waitlist, if appropriate.

If the Intake Specialist determines that the applicant does not meet the FE Waiver criteria including, LOC, or ongoing waiver service need, the applicant will be referred to other agencies and community resources for services and/or assistance.

Once a waiver slot becomes available, the applicant will be provided information regarding ongoing case management services and will be offered a choice between Case Management agencies. When a waiver slot is available a financial application is submitted to the DWSS office to determine financial eligibility, and upon approval, the final determination for eligibility is made by the DHCFP LTSS.

g. Reevaluation Schedule. Per 42 CFR § 441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**

  Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**

  Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR § 441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care *(specify):*

The LOC assessment is an integral part of case management services. The annual reevaluation of eligibility and LOC is an administrative Case Management function. The Case Management provider maintains a case management database, which provides notification when a reassessment is due. Waiver eligibility must be reassessed annually. The case managers scheduled the reassessment visits up to 45 days prior to the annual anniversary.
Upon reassessment, the ADSD Operations Agency completes a desk audit review of all LOC determinations to ensure eligibility criteria is met in accordance with waiver requirements.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR § 441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR § 92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

An individual record is established for each waiver recipient in electronic and/or written format. Records of assessments and reassessments of LOC are maintained in the following location(s): by the agency designated in Appendix A as having primary authority for the daily operation of the waiver program; at the office for the geographic area in which the recipient resides; by the persons or agencies designated as responsible for the performance of assessments and reassessments. Written or electronically retrievable documentation of all assessments and reassessments are maintained for a minimum period of 6 (six) years after the date the last claim was paid for waiver services for each recipient.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of new applicants who receive a LOC evaluation prior to receiving services. Numerator: Number of new applicants who receive a LOC evaluation prior to receiving services. Denominator: Number of new applicants who apply for waiver services.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of enrolled recipients whose Level of Care was reevaluated annually. Numerator: Number of enrolled recipients whose Level of Care was reevaluated annually. Denominator: Number of enrolled recipients reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval =

		95% confidence level and +/- 5% margin of error
☒ **Other** Specify: Case Management Providers	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of recipients whose LOC eligibility was based on accurate application of policy resulting in accurate LOC determinations. N: number of recipients whose LOC eligibility was based on accurate application of policy resulting in accurate LOC determinations, D: number of recipients reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☒ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level and +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The Operations Agency reviews 100% of LOC evaluations to assure accurate LOC determination based on the recipient's functional deficits and appropriateness for program eligibility using a Level of Care scorecard format.

At the quarterly QM meetings between DHCFP LTSS and QA, and ADSD Operations, DHCFP LTSS reports on the review findings of intake packets that are reviewed prior to approval.

Case Managers conduct LOC reevaluations which are reviewed by the Operations Agency for accuracy according to policy, at 100%. Case Managers monitor redetermination dates to ensure the LOC is completed as required. Any errors or concerns the Operating Agency identifies are communicated to the Case Management provider for correction and/or clarification. The Operations Agency reports the data at the quarterly QM meetings for recommendations, remedial action, and improvement strategies.

Additional monitoring by DHCFP is accomplished using an annual review approach. The DHCFP QA annual review is designed as a look-back review to confirm the data. If issues are discovered during the annual review, the review is expanded to determine the extent of the problem, which will be addressed in the quality improvement meetings. Furthermore, DHCFP LTSS will conduct a 95/5 sample of LOC re-evaluations to ensure waiver requirements are met.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The Operations Agency supervisory staff addresses concerns or issues as they are identified with the Intake Specialist. The supervisor reviews a sample of intake packets to ensure the individual meets the required LOC score, has a waiver service need, and meets other eligibility criteria determined by the Operating Agency.

Reassessment data is reviewed and analyzed during the quarterly quality improvement (QI) meetings hosted by the DHCFP QA, with the DHCFP LTSS, ADSD QA and the Operations Agency in attendance. The analysis will determine trends, areas of concern and deficiencies that require a corrective action strategy to be communicated from the DHCFP QA unit to the Case Management providers. Additionally, the ADSD Operations Agency will present the LOC data to review and determine areas of improvement, corrective action, and communication to the Case Management providers as appropriate. DHCFP LTSS will be conducting a review of a 95/5 sample of LOC re-evaluation to ensure compliance with waiver requirements.

Additionally, DHCFP LTSS, facilitates the quarterly consistency meeting with DHCFP QA, ADSD Operations Agency and QA. The purpose of consistency meetings is to review, update and/or revise performance measures (PM), to ensure waiver assurances and sub-assurances are being captured and met; case file review tools to ensure up-to-date versions are being utilized and aligned across entities; DHCFP LTSS provides updates of waiver policy changes, amendments and renewals.

Each Case Management provider is responsible to develop internal quality measures to ensure appropriate actions are taken. Remedial activities will be communicated to the DHCFP QA/Operations Agency as requested.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other**	☒ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR § 441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Applicants are given a description of services available through the waiver during the intake process. The Operations Agency Intake Specialist informs the applicant of their choice between waiver services or an institutional setting, in addition to their choice of qualified providers.

Service providers are required to be an agency employee for billing, oversight, and or training purposes.

The person-centered planning process is driven by the individual, designated representative, LRI, or other supports chosen by the individual and includes necessary information and support to ensure that the individual directs the process to the maximum extent possible.

Prior to entrance to the waiver, and during annual re-assessment, all waiver applicants/recipients must read, or have read to them, the Statement of Choice (SOC). This form must be acknowledged by the applicant/recipient via signature and date. This form addresses their choice between institutional placement of home and community-based services.

The information reviewed with the recipient/designated representative/LRI include: process for development of the PCSP, services to be provided, and choice of service provider. The recipient may request a change in services or service provider at any time.

The Operations Agency Intake Specialist and Case Managers will assist the applicants/recipient in gaining access to necessary State Plan and Waiver services, as well as needed medical, social, educational, and other services, regardless of funding sources.

For applicants/recipients who are non-English speakers, DHCFP utilizes Limited English Proficiency services through Language Link, which also provides Sign Language Interpretation Services and is contracted by DHCFP.

b. Maintenance of Forms. Per 45 CFR § 92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

A record is established for each recipient. One copy of the SOC is filed in the recipient's case record in the office of the geographic region that the recipient resides and a copy is provided to the recipient. The recipient's permanent case file will be scanned into an electronic case file which is accessible to authorized parties. Case files (hard copy or electronic) are maintained for as long as an individual is on the waiver, or for six (6) years after waiver services end.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The State makes every effort to inform recipients of waiver information in their language. The Nevada State Purchasing Division has awarded contracts for telephone-based interpreter services. Case Management providers may employ staff who are certified as a “dual-role interpreter.” For those languages where certified bilingual staff are not available, translation services are utilized through the contracted state vendors. Vendors, rates, and contract expiration dates are posted on the State of Nevada Department of Administration Purchasing Division website.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	**Case Management**		

Service Type	Service		
Statutory Service	Homemaker		
Statutory Service	Respite		
Other Service	Adult Companion		
Other Service	Adult Day Care		
Other Service	Augmented Personal Care (APC)		
Other Service	Chore		
Other Service	Home Delivered Meals		
Other Service	Personal Emergency Response System (PERS)		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Case Management services assist eligible and active Waiver participants in gaining access to needed Waiver and other State Plan services, as well as needed medical, social, education or other services, regardless of the funding source for the services to which access is gained. Case Managers are responsible for ongoing monitoring of the provision of services included in the individual's Person-Centered Service Plan (PCSP). Case Management services can be provided by public (ADSD) or private case management agencies.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Case Management (Private)
Agency	Case Management (Public)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

Case Management (Private)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Case Management providers must be enrolled as a Waiver Case Management Provider Agency through DHCFP's fiscal agent.

Meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to the DHCFP Medicaid Services Manual (MSM), Chapters 100 and 2200.

Meet all conditions of participation in MSM Chapter 100 Section 102.1.

The following requirements must be verified upon enrollment:
• Documentation of taxpayer ID
• Business license from the Secretary of State (for in-state providers) or a copy of the Secretary of State business license in the provider's home state (for out-of-state provider).
• Proof of Worker's Compensation Insurance
• Proof of Unemployment Insurance Account
• Proof of Commercial General Liability
• Proof of Business Automobile Liability Coverage
• Proof of Commercial Crime Insurance
• Local or toll-free phone number accessible during traditional business hours (8:00 am- 5:00 pm).
• Business office that is accessible to the public during established and posted business hours OR demonstrate availability to waiver individuals during traditional business hours (8:00 am- 5:00 pm).
• FBI Criminal Background Check

Employees who provide case management must meet the following requirements:
• Have a valid driver's license and means of transportation to enable home visits.
• Adhere to Health Insurance Portability and Accountability Act (HIPAA) requirements.
• FBI criminal history background check.
• Licensed as a Social Worker by the State of Nevada Board of Examiners for Social Workers, licensed as a Registered Nurse by the State of Nevada Board of Nursing, Or have a professional license or certificate in a medical specialty applicable to the assignment; OR have at minimum a Bachelor's degree from an accredited college or university in social work, gerontology, counseling, nursing, psychology, human growth and development, special education, sociology, criminal justice or a closely related social science or human services field. One year of professional experience providing case management services in a social or health related field is preferred but can be obtained through on the job training; or have an equivalent combination of education and experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCFP, DHCFP's Fiscal Agent and ADSD

Frequency of Verification:

Upon initial enrollment with DHCFP's Fiscal Agent and every five (5) years at re-validation and as a part of ADSD Quality Assurance activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

Case Management (Public)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must be enrolled as a waiver case management provider agency through DHCFP's fiscal agent.

Meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to the DHCFP Medicaid Services Manual (MSM), Chapters 100 and 2200, as applicable.

Meet all conditions of participation in MSM Chapter 100 Section 102.1.

Employees who provide case management must meet the requirements listed above and:
• Have a valid driver's license and means of transportation to enable home visits.
• Adhere to Health Insurance Portability and Accountability Act (HIPAA) requirements.
• FBI criminal history background check.
• Licensed Social Worker by the State of Nevada Board of Examiners for Social Workers, licensed as a Registered Nurse by the State of Nevada Board of Nursing, or have a professional license or certificate in a medical specialty applicable to the assignment; OR have at minimum a Bachelor's degree from an accredited college or university in social work, gerontology, counseling, nursing, psychology, human growth and development, special education, sociology, criminal justice or a closely related social science or human services field. One year of professional experience providing case management services in a social or health related field is preferred but can be obtained through on the job training; or have an equivalent combination of education and experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCFP, DHCFP's Fiscal Agent and ADSD

Frequency of Verification:

Upon initial employment. ADSD will verify employee qualifications are maintained appropriately.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08050 homemaker
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Services consisting of the performance of general household tasks (e.g. light housekeeping, meal preparation, essential shopping, and laundry and routine household care). These services are provided when the individual regularly responsible for these activities is temporarily absent or unable to manage the home.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Services must be prior authorized by the Case Manager.

Up to two (2) hours/week if the LRI is a live-in caregiver and for LRI non-live-caregiver – will be based on the case manager's assessment of the recipient's living condition e.g., living alone and risk level.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**
- [ ] **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- [x] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Homemaker

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Homemaker

Provider Qualifications

License *(specify):*

Current enrollment as a Provider Type 30 (Personal Care Services – Provider Agency) or PT 83 (Personal Care Service – Intermediary Services Organization (ISO) in the Nevada Medicaid Program.

OR EACH OF THE FOLLOWING:

- Licensure as a Personal Care Attendant issued by the State of Nevada Department of Health and Human Services Division of Public and Behavioral Health (DPBH).
- Documentation showing Taxpayer Identification Number (SS-4 or CP575 or W-9 or Social Security Card).
- Proof of Worker's Compensation Insurance.
- Proof of Commercial General Liability Insurance of not less than $2 million general aggregate and $1 million each occurrence, with the Nevada Division of Health Care Financing and Policy (DHCFP)named as an additional insured. DHCFP's address is 1100 E. William St., Ste. 101, Carson City, Nevada 89701.
- Proof of Commercial Crime Insurance for employee dishonesty with a minimum of $25,000 per loss. Policy must name DHCFP as an additional insured.
- Proof of Business Automobile Insurance with a minimum coverage of $750,000 combined single limit for bodily injury and property damage for any owned, leased, hired and non-owned vehicles used in the performance of the Medicaid provider's Contract. The policy must name DHCFP as an additional insured and shall be endorsed to include the following language: "The State of Nevada shall be named as an additional insured with respect to liability arising out of the activities performed by, or on behalf of the Contractor, including automobiles owned, leased, hired or borrowed by the Contractor."
- Signed Business Associate Addendum (NMH-3820).
- Completed Medicaid Electronic Visit Verification (EVV) Provider System Selection Form and attach to your enrollment/revalidation.
- Must sign an attestation agreeing to pay direct home care workers (employed and contracted) a minimum of at least $16 per hour of the total $25 per hour rate approved for this service will be passed directly to the individual rendering the service. In the event a provider does not comply with the minimum wage requirement above, corrective action may be taken up to and including reimbursing providers at the previous rates in effect December 31, 2023.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCFP's fiscal agent.

Frequency of Verification:

Upon initial enrollment and every five (5) years for revalidation.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09012 respite, in-home
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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. Respite providers provide general assistance with ADLs and IADLs, as well as provide supervision for recipients with functional impairments in their home or place of residence (community setting). Services may be for 24-hour periods, and the goal is relief of the primary caregiver.

Respite services are only provided in the recipient's home.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Respite care is limited to 336 hours for the duration of the Plan of Care.
Services must be prior authorized by the Case Manager.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☒ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Respite, waiver

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Respite, waiver

Provider Qualifications

License *(specify):*

Current enrollment as a Provider Type 30 (Personal Care Services - Provider Agency) or 83 (Personal Care Services -Intermediary Service Organization) in the Nevada Medicaid Program.

OR EACH OF THE FOLLOWING

- Licensure as a Personal Care Agency issued by the State of Nevada Department of Health and Human Services Division of Public and Behavioral Health (DPBH).
- Documentation showing Taxpayer Identification Number (SS-4 or CP575 or W-9 or Social Security Card).
- Proof of Worker's Compensation Insurance.
- Proof of Commercial General Liability Insurance of not less than $2 million general aggregate and $1 million each occurrence, with the Nevada Division of Health Care Financing and Policy (DHCFP) named as an additional insured. DHCFP's address is 1100 E. William St., Ste. 101, Carson City, Nevada 89701.
- Proof of Commercial Crime Insurance for employee dishonesty with a minimum of $25,000 per loss. Policy must name DHCFP as an additional insured.
- Proof of Business Automobile Insurance with a minimum coverage of $750,000 combined single limit for bodily injury and property damage for any owned, leased, hired and non-owned vehicles used in the performance of the Medicaid provider's Contract. The policy must name DHCFP as an additional insured and shall be endorsed to include the following language: "The State of Nevada shall be named as an additional insured with respect to liability arising out of the activities performed by, or on behalf of the Contractor, including automobiles owned, leased, hired or borrowed by the Contractor."
- Signed Business Associate Addendum (NMH-3820).
- Completed Medicaid Electronic Visit Verification (EVV) Provider System Selection Form and attach to your enrollment/revalidation.
- Must sign an attestation agreeing to pay direct home care workers (employed and contracted) a minimum of at least $16 per hour of the total $25 per hour rate approved for this service will be passed directly to the individual rendering the service. In the event a provider does not comply with the minimum wage requirement above, corrective action may be taken up to and including reimbursing providers at the previous rates in effect December 31, 2023.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCFP's fiscal agent.

Frequency of Verification:

Upon initial enrollment and every five (5) years for revalidation.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through

the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR Â§440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Adult Companion

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
08 Home-Based Services	08040 companion
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Non-medical care, supervision and socialization, provided to a functionally impaired adult in his/her own home. Adult Companion may assist or supervise the recipient with such tasks as meal preparation and clean up, laundry, light housekeeping, shopping and facilitate transportation and escort, but do not perform these activities as distinct services. Providers may also perform light housekeeping tasks, which are incidental to the care and supervision of the recipient. When the recipient receives Personal Care, Chore and/or Homemaker services, Adult Companion service must not duplicate the delivery of these services. This service is provided in accordance with a goal in the Plan of Care, and is not purely diversional in nature.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service must not be provided in a residential for group or assisted living facility.

LRIs are allowed to provide this service only when no other similar services are in place such as Adult Day Care or living in a residential group home. Limit to two (2) hours/day and is based on the case manager's assessment and only if the primary and live-in caregiver needs a break or to run errands, etc.

Services must be prior authorized by the Case Manager.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒

☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)*:

☒ **Legally Responsible Person**
☒ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Companion

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Companion

Provider Category:
Agency
Provider Type:

Adult Companion

Provider Qualifications

License *(specify):*

Current enrollment as a Provider Type 30 (Personal Care Services - Provider Agency) or 83 (Personal Care Services - Intermediary Service Organization) in the Nevada Medicaid Program.

OR EACH OF THE FOLLOWING

- Licensure as a Personal Care Agency issued by the State of Nevada Department of Health and Human Services Division of Public and Behavioral Health (DPBH).
- Documentation showing Taxpayer Identification Number (SS-4 or CP575 or W-9 or Social Security Card).
- Proof of Worker's Compensation Insurance
- Proof of Commercial General Liability Insurance of not less than $2 million general aggregate and $1 million each occurrence, with the Nevada Division of Health Care Financing and Policy (DHCFP) named as an additional insured. DHCFP's address is 1100 E. William St., Ste. 101, Carson City, Nevada 89701.
- Proof of Commercial Crime Insurance for employee dishonesty with a minimum of $25,000 per loss. Policy must name DHCFP as an additional insured.
- Proof of Business Automobile Insurance with a minimum coverage of $750,000 combined single limit for bodily injury and property damage for any owned, leased, hired and non-owned vehicles used in the performance of the Medicaid provider's Contract. The policy must name DHCFP as an additional insured and shall be endorsed to include the following language: "The State of Nevada shall be named as an additional insured with respect to liability arising out of the activities performed by, or on behalf of the Contractor, including automobiles owned, leased, hired or borrowed by the Contractor."
- Signed Business Associate Addendum (NMH 3820).
- Complete the Medicaid Electronic Visit.
- • Must sign an attestation agreeing to pay direct home care workers (employed and contracted) a minimum of at least $16 per hour of the total $25 per hour rate approved for this service will be passed directly to the individual rendering the service. In the event a provider does not comply with the minimum wage requirement above, corrective action may be taken up to and including reimbursing providers at the previous rates in effect December 31, 2023.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCFP's fiscal agent.

Frequency of Verification:

Upon initial enrollment and every five (5) years at revalidation.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR Â§440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Adult Day Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04060 adult day services (social model)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Adult day care is a service provided for one or more days per week as authorized in the POC. These services are furnished in a non-institutional community based setting including home environment, 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 personalized goals in the POC.

Transportation is not provided as a component of Adult Day Care service; however, providers can get reimburse under State Plan Non - Emergency Transportation (NET). DHCFP contracted a vendor to handle and pay for all Medicaid recipients non-emergency transportation requests.

Therapies (if needed) are furnished separate from the adult day care waiver service and is paid for under the State Plan programs.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Adult Day Care can be authorized per diem maximum of 6 hours, or per unit (15 minutes) if the recipient is in attendance for less than 6 hours.

Services must be prior authorized by the Case Manager.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Care Facility

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Day Care

Provider Category:

Agency

Provider Type:

Adult Day Care Facility

Provider Qualifications

License *(specify):*

• Licensure as an Adult Day Care (ADC) facilities agency issued by the State of Nevada Department of Health and Human Services Division of Public and Behavioral Health (DPBH).
• Documentation showing Taxpayer Identification Number (SS-4 or CP575 or W-9 or Social Security Card).
• Proof of Worker's Compensation Insurance.
• Proof of Commercial General Liability Insurance of not less than $2 million general aggregate and $1 million each occurrence, with the Nevada Division of Health Care Financing and Policy (DHCFP) named as an additional insured. DHCFP's address is 1100 E. William St., Ste. 101, Carson City, Nevada 89701.
• Proof of Commercial Crime Insurance for employee dishonesty with a minimum of $25,000 per loss. Policy must name DHCFP as an additional insured.
• Do you provide transportation in any owned, leased, hired and non-owned vehicles?
• Yes No If you answered "Yes" you must provide Proof of Business Automobile Insurance, with a minimum coverage of $750,000 combined single limit for bodily injury and property damage for any owned, leased, hired and non-owned vehicles used in the performance of the Medicaid provider's Contract. The policy must name DHCFP as an additional insured and shall be endorsed to include the following language: "The State of Nevada shall be named as an additional insured with respect to liability arising out of the activities performed by, or on behalf of the Contractor, including automobiles owned, leased, hired or borrowed by the Contractor."
• Signed Business Associate Addendum (NMH-3820).

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCFP's fiscal agent.

Frequency of Verification:

Upon initial enrollment and every five (5) years at revalidation.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR Â§440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Augmented Personal Care (APC)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02013 group living, other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Personal care and supportive services (homemaker, chore, attendant services, meal preparation) that are furnished to waiver participants who reside in a setting that meets the HCBS settings requirements and includes 24-hour on-site response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security. Services also include social and recreational programming, 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.

Augmented personal care is over and above the mandatory service provision required by regulation, which includes the coordination of transportation to and from the residential facility for groups to the hospital, a nursing facility, routine medical appointments and social outings organized by the facility.

Other individuals or agencies may also furnish care directly, or under arrangement with the group home or assisted living, but the care provided by these other entities is supplemental and does not relieve the group home or assisted living facility from their primary care duties.

Nursing and skilled therapy services (except periodic nursing evaluations if specified above) are incidental, rather than integral to the provision of group care and assisted living services. Payment will not be made for 24-hour skilled care or supervision. Federal Financial Participation (FFP) 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.

There are four levels of augmented personal care covered in this waiver. The service level provided is based on the recipients functional, cognitive and behavioral needs to ensure his or her health, safety and welfare in the community. The case manager determines the service level.

Level One Daily (minimum assistance)
Requires supervision and cueing to complete basic self care and ADLs with minimum hands on care; in home supervision when direct care tasks are not being completed. Minimum assistance with laundry; housekeeping; meal preparation and eating; bed mobility and transfers; bathing, dressing and grooming; mobility and ambulation.

Level Two Daily (moderate assistance)
Requires physical assistance to complete ADLs with moderate hands on care; in home supervision with regularly scheduled checks as needed. Moderate assistance with increased laundry needs; housekeeping; special meal prep and eating; bed mobility and transfers; bathing, dressing and grooming; mobility and ambulation.

Level Three Daily (maximum assistance)
Requires physical assistance to complete ADLs with maximum hands on care; direct 24 hour supervision and/or safety system (alarm) to ensure safety when supervision is not direct. Maximum assistance with increased laundry needs; housekeeping; special meal prep and eating; bed mobility and transfers; bathing, dressing and grooming; mobility and ambulation.

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

*All service levels are reassessed annually, or as significant changes occur, and may increase or decrease to reflect the recipients current level of need. Cognitive and/or critical behaviors are considered in the Level of Care Determination and may cause a recipient to be assessed at a different APC Level than originally determined.

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

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The only limit is licensure by the Bureau of Health Care Quality and Compliance (HCQC). HCQC licenses residential facilities for group based on the level of service as identified under the service specifications.

APC can only be provided in the residential group home or assisted living and not to be combine with State Plan PCS.

APC must be prior authorized by the Case Manager before services can start and identified on the POC.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Residential Facility for Groups
Agency	Assisted Living

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Augmented Personal Care (APC)

Provider Category:

Agency

Provider Type:

Residential Facility for Groups

Provider Qualifications

License *(specify):*

• Licensure as an agency to provide Residential Facilities for Groups issued by the State of Nevada Department of Health and Human Services Division of Public and Behavioral Health (DPBH)- Bureau of Health Care Quality and Compliance (HCQC).
• Documentation showing Taxpayer Identification Number (SS-4, CP575, W-9 or Social Security Card).
• Proof of Worker's Compensation Insurance.
• Proof of Commercial General Liability Insurance of not less than $2 million general aggregate and $1 million each occurrence, with the Nevada Division of Health Care Financing and Policy (DHCFP) named as an additional insured. DHCFP's address is 1100 E. William St., Ste. 101, Carson City, Nevada 89701.
• Signed Business Associate Addendum (NMH-3820).
• Must sign an attestation agreeing to pay direct home care workers (employed and contracted) a minimum of at least $16 per hour of the total $25 per hour rate approved for this service will be passed directly to the individual rendering the service. In the event a provider does not comply with the minimum wage requirement above, corrective action may be taken up to and including reimbursing providers at the previous rates in effect December 31, 2023.

Certificate *(specify):*

Other Standard *(specify):*

Group home staff will be trained in the functional care skills that are needed to care for each unique recipient. Training will include but not be limited to techniques such as transfers, mobility, positioning, use of special equipment, identification of signs of distress, First Aid and CPR.

Per HCQC all employees/caregivers of residential group homes must have the following qualifications and training:
NAC449.196Qualifications and training of caregivers https://www.leg.state.nv.us/NRS/NRS-449.html#NRS449Sec0302

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCFP's Fiscal Agent, HCQC and ADSD

In addition to HCQC oversight, ADSD QA conducts provider reviews of the Residential Facility for Groups and all waiver providers annually. As part of case management service, ADSD case manager (CM) also contacts recipients (in their place of residency) to ensure safety and well-being of the recipient. The CM contact can be monthly or as indicated on the POC and by telephone or home/facility visit. During CM's visit, they also obtain daily records/logs of the recipients for review.

Frequency of Verification:

Fiscal Agent - Upon initial enrollment and every five (5) years at revalidation

ADSD QA - Annually

CM - monthly or as needed phone or face-to-face visit contact (per POC))with recipient in the residential group home or assisted living.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Augmented Personal Care (APC)

Provider Category:

Agency

Provider Type:

Assisted Living

Provider Qualifications

License *(specify):*

• Licensure as an agency to provide Residential Facilities for Groups issued by the State of Nevada Department of Health and Human Services Division of Public and Behavioral Health (DPBH).
• Documentation showing Taxpayer Identification Number (SS-4, CP575, W-9 or Social Security Card).
• Proof of Worker's Compensation Insurance.
• Proof of Commercial General Liability Insurance of not less than $2 million general aggregate and $1 million each occurrence, with the Nevada Division of Health Care Financing and Policy (DHCFP) named as an additional insured. DHCFP's address is 1100 E. William St., Ste. 101, Carson City, Nevada 89701.
• Proof of Commercial Crime Insurance for employee dishonesty with minimum of $25,000 per loss. Policy must name DHCFP as an additional insured.
• Proof of Business Automobile Insurance, with a minimum coverage of $750,000 combined single limit for bodily injury and property damage for any owned, leased, hired and non-owned vehicles used in the performance of the Medicaid provider's Contract. The policy must name DHCFP as an additional insured and shall be endorsed to include the following language: "The State of Nevada shall be named as an additional insured with respect to liability arising out of the activities performed by, or on behalf of, the Contractor, including automobiles owned, leased, hired or borrowed by the Contractor."
• Signed Business Associate Addendum (NMH-3820).

Certificate *(specify):*

Other Standard *(specify):*

Additional Qualifications for Assisted Living Providers include:
Assisted Living staff will be trained in the functional care skills that are needed to care for each unique recipient. Training will include but not be limited to techniques such as transfers, mobility, positioning, use of special equipment, identification of signs of distress, First Aid and CPR.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCFP's Fiscal Agent

Frequency of Verification:

Upon initial enrollment and every five (5) years at revalidation.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR Â§440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Chore

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08060 chore
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Chore services are intermittent in nature and may be authorized as a need arises for the completion of a specific task which otherwise left undone poses a home safety issue. The service must be identified on the POC.

For LRI providers - this service will be based on the case manager assessment and only if the primary caregiver (live-in) needs assistance and that the LRI is a non-live-in caregiver. This service is on a as needed basis.

Services must be prior authorized by the Case Manager.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☒ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Chore

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Chore

Provider Category:

Agency

Provider Type:

Chore

Provider Qualifications

License *(specify):*

• Current enrollment as a Provider Type 30 (Personal Care Services - Provider Agency) or 83 (Personal Care Services -Intermediary Service Organization) in the Nevada Medicaid Program.

OR EACH OF THE FOLLOWING

• Documentation showing Taxpayer Identification Number (SS-4 or CP575 or W-9 or Social Security Card).
• Proof of Worker's Compensation Insurance.
• Copy of business license from the Nevada Secretary of State (for in-state providers) or a copy of the Secretary of State business license in the provider's home state (for out-of-state providers).
• Signed Business Associate Addendum (NMH 3820)
• Complete the Medicaid Electronic Visit Verification (EVV) Provider System Selection Form and attach to your enrollment/revalidation.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCFP's fiscal agent.

Frequency of Verification:

Upon initial enrollment and every five (5) years at revalidation.

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR Â§440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Delivered Meals

HCBS Taxonomy:

Category 1:	Sub-Category 1:
06 Home Delivered Meals	06010 home delivered meals
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Home delivered meals are the provision of meals to seniors at risk of institutional care due to inadequate nutrition because of COVID-19 crisis and increase cost of food that impacted homebound seniors. Home delivered meals include the planning, purchase, preparation and delivery or transportation costs of meals to senior’s home.

Recipients who require home delivered meals are unable to prepare or obtain nutritional meals without assistance or are unable to manage a special diet recommended by their physician.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Home Delivered Meals are limited to two meals per day.

Service must be prior authorized by the case manager.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**
☐ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency for Home Delivered Meals

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Agency for Home Delivered Meals

Provider Qualifications

License *(specify):*

Business license from the Secretary of State (for in-state providers) or a copy of the Secretary of State business license in the provider's home state (for out-of-state provider).

Certificate *(specify):*

None

Other Standard *(specify):*

Documentation showing taxpayer identification number (SS-4 or CP575 or W-9 or Social Security Card).

A food service establishment permit pursuant to NRS 446. National Provider Identifier (NPI) validation. Signed Business Associate Addendum.

All kitchen staff must hold a valid health certificate if required by local health ordinances.

All providers must comply with applicable federal, state and local code and regulations relating to the public health, safety, and welfare, and to food preparation as required in all stages of food service operation.

Copies of all current inspection reports by health department staff, registered sanitarian, or fire officials should be kept on file by the provider and posted at the meal preparation site.

All meals must comply with the Dietary Guidelines for Americans published by the Secretaries of the Department of Health and Human Services and the U. S. Department of Agriculture and provide a minimum of one-third of the current daily Recommended Dietary Allowances as established by the Food and Nutrition Board, National Research Council of the National Academy of Sciences.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCFP's fiscal agent.

Frequency of Verification:

Upon initial enrollment and every five (5) years at revalidation.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR Â§440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Emergency Response System (PERS)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

PERS is an electronic device which enables waiver participants 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. The service components include both the installation of the unit and monthly monitoring.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Two separate authorizations are required for payment; the initial installation fee for the device and a monthly fee for continuous monitoring.

Service must be prior authorized by the Case Manager.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Emergency Response System (PERS)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response System (PERS)

Provider Category:

Agency

Provider Type:

Personal Emergency Response System (PERS)

Provider Qualifications

License *(specify):*

• Documentation showing Taxpayer Identification Number (SS-4 or CP575 or W-9 or Social Security Card)
• Copy of business license from the Nevada Secretary of State (for in-state providers) or a copy of the Secretary of State business license in the provider's home state (for out of state providers)
• Signed Business Associate Addendum (NMH-3820).

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCFP's fiscal agent.

Frequency of Verification:

Upon initial enrollment and every five (5) years at revalidation.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☒ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management).** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

Direct Service Case Management is limited to eligible participants enrolled in a the FE Waiver. Case Management is identified as a service on the POC. The recipient has a choice of case management services to be provided by public or private case management providers.

Public case management is offered by the ADSD who is enrolled with the DHCFP and hire qualified Case Managers for the FE Waiver. Private case management is offered through privately operated case management companies who enroll with the DHCFP and hire qualified Case Managers for the FE Waiver.

d. Remote/Telehealth Delivery of Waiver Services. Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

Service
Case Management
Homemaker

Service
Respite
Adult Companion
Adult Day Care
Augmented Personal Care (APC)
Chore
Home Delivered Meals
Personal Emergency Response System (PERS)

1. Will any in-person visits be required?

- ○ **Yes.**
- ○ **No.**

2. *By checking each box below, the state assures that it will address the following when delivering the service remotely/via telehealth.*

☐ **The remote service will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc.** ***Explain:***

☐ **How the telehealth service delivery will facilitate community integration.** ***Explain:***

☐ **How the telehealth will ensure the successful delivery of services for individuals who need hands on assistance/physical assistance, including whether the service can be rendered without someone who is physically present or is separated from the individual.** ***Explain:***

☐ **How the state will support individuals who need assistance with using the technology required for telehealth delivery of the service.** ***Explain:***

☐ **How the telehealth will ensure the health and safety of an individual.** ***Explain:***

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

For purposes of this Waiver, non-Legally Responsible Individual (LRI) relatives and LRIs, who want to be personal caregivers of waiver recipients must adhere to the same requirements as non-relative personal caregivers. Relatives and LRIs must be enrolled with Personal Care Agencies prior to providing waiver services to recipients in order to be reimbursed for services rendered. All Medicaid Waiver Providers including personal care agencies and their respective caregivers are subject to criminal background checks.

AGING AND DISABILITY SERVICES DIVISION (ADSD) EMPLOYEES:

ADSD, in compliance with the Department of Health and Human Services (DHHS), requires a criminal background check of any person appointed to a position in the classified or unclassified service whose duties include regular or potential contact with applicants/recipients of the Division or access to applicant/recipient records. State agencies use NRS 239B.010 “request by agency of State or political subdivision for information on certain persons from Federal Bureau of Investigation” as the citation to request background checks. A criminal background check is required as a condition of employment for any person accepting employment with the agency, to include appointment as a new hire, reinstatement, reemployment, reappointment or transfer.

Employees are fingerprinted within five working days of their date of hire or appointment.

It is the responsibility of an employee’s supervisor to ensure fingerprint cards are completed and submitted to the designated Division Personnel Staff who has the responsibility of submitting the fingerprint cards to Central Repository for Nevada Records of Criminal History, an agency of the Nevada Department of Public Safety, Records and Technology Division. The results of the state and national FBI criminal history search are transmitted back to Personnel, who notify the ADSD Administrator or Deputy Administrator of any positive results. The ADSD Administrator or Deputy Administrator takes any action necessary as a result of the background check.

WAIVER PROVIDERS:

The DHCFP policy requires all waiver providers to have State and Federal criminal history background checks completed. Based on the results of the background check, the DHCFP fiscal agent will not enroll any provider agency whose operator has been convicted of a felony under Federal or State law for any offense which DHCFP determines is inconsistent with the best interest of recipients.

A fingerprint based criminal background check is required for all employees who provide direct care to recipients, as well as owners and administrators. Internet based background checks are not acceptable.

The DHCFP policy requires all providers have a fingerprint based criminal history completed prior to service initiation, and every five years thereafter. The DHCFP fiscal agent will not enroll any provider agency whose owner or operator has been convicted of a felony under State or Federal law for any offense which the DHCFP determines is inconsistent with the best interest of recipients. Additional information may be found in MSM Chapter 100, Section 102.2, which outlines a list of crimes which are inconsistent with the best interests of the recipients, and MSM Chapter 2600 Section 2603.8(1)for ISO requirements for caregivers including relatives.

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

The employer is responsible for reviewing the results of employee criminal background checks and maintaining the results within the employee’s personnel records. Continued employment is at the sole discretion of the servicing agency. However, the DHCFP has determined certain felonies and misdemeanors to be inconsistent with the best interests of recipients. The employer should gather information regarding the circumstances surrounding the conviction when considering ongoing employment and have this documented in the employee’s personnel file. These convictions include (not all inclusive):
1. Murder, voluntary manslaughter or mayhem;
2. Assault with intent to kill or to commit sexual assault or mayhem;
3. Sexual assault, statutory sexual seduction, incest, lewdness, indecent exposure or any other sexually related crime;
4. Abuse or neglect of a child or contributory delinquency;

5. A violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in NRS 454;
6. A violation of any provision of NRS 200.700 through 200.760;
7. Criminal neglect of a patient as defined in NRS 200.495;
8. Any offense involving fraud, theft, embezzlement, burglary, robbery, fraudulent conversion or misappropriation of property;
9. Any felony involving the use of a firearm or other deadly weapon;
10. Abuse, neglect, exploitation or isolation of older persons;
11. Kidnapping, false imprisonment or involuntary servitude;
12. Any offense involving assault or battery, domestic or otherwise;
13. Conduct inimical to the public health, morals, welfare and safety of the people of the State of Nevada in the maintenance and operation of the premises for which a provider contract is issued;
14. Conduct or practice detrimental to the health or safety of the occupants or employees of the facility or agency; or
15. Any other offense that may be inconsistent with the best interests of all recipients.

Providers are required to initiate diligent and effective follow up for results of background checks within ninety (90) days of submission of prints and continue until results are received. An “undecided” result is not acceptable. If an employee believes that the information provided as a result of the criminal background check is incorrect, the individual must immediately inform the employing agency in writing. Information regarding challenging a disqualification is found on the DPS website at: http://dps.nv.gov under Records and Technology.

Residential Facilities for Groups (RFG) and Assisted Living (AL) Facilities:

Additional requirements for RFGs and AL under Nevada Revised Statute 449.

Employers of RFGs and ALs are required to conduct FBI background checks on all employees within 10 days after hiring an employee and must:

(a) Obtain a written statement from the employee stating whether he has been convicted of any crime listed in NRS 449.188;
(b) Obtain an oral and written confirmation of the information contained in the written statement obtained pursuant to paragraph (a);
(c) Obtain from the employee two sets of fingerprints and a written authorization to forward the fingerprints to the Central Repository for Nevada Records of Criminal History for submission to the FBI for its report.

DHCFP verifies background checks on service providers/employees upon enrollment and at 5 years for re-validation thereafter.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- ◉ **No. The state does not conduct abuse registry screening.**
- ○ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

Note: Required information from this page is contained in response to C-5.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *Select one*:

- ○ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ◉ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is ***"extraordinary care"***, exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

Legally Responsible Individuals (LRI) include: spouses of recipients, legal guardians, and parents of minor recipients, including: stepparents, foster parents and adoptive parents. Using the person-centered approach, the recipients are provided the freedom to choose their personal caregiver.

Nevada has experienced an increased shortage of Caregiver agencies and Caregiver staff resulting in many recipients relying on LRIs to provide necessary care. Much of Nevada is rural and frontier which has added to this shortfall and created an additional dependence on LRIs above the scope of normal activities expected of them due to the LRI status. Such limitations could include the lack of other providers who are available to serve the participant during periods when the legally responsible individual would otherwise be absent from the home and, thereby, must remain in the home to care for the recipient. Allowing LRIs to be paid to provide activities that family caregivers would not ordinarily perform or are not responsible to perform, is considered extraordinary care and is reimbursable under the Waiver.

LRIs may provide the following waiver services:
Homemaker – up to 2 hours/week if the LRI is a live-in caregiver and for LRI non-live-caregiver – will be based on the case manager's assessment of the recipient's living condition e.g., living alone and risk level.
Respite
Chore – this will be based on the case manager assessment and only if the primary caregiver (live-in) needs assistance and that the LRI is a non-live-in caregiver. This service is on a as needed basis.
Adult Companion – only available when no other similar services are in place such as Adult Day Care or living in a residential group home. Limit to two (2) hours/day and is based on the case manager's assessment and only if the primary and live-in caregiver needs a break or to run errands, etc.

For LRIs to be paid to provide the above services as specified in C-1/C-3:
1. Must be recipient's choice for the LRI to provide the services, which is achieved through the person-centered Plan of Care (POC)
development;
2. If chosen by recipient, recipient or designated representative (not the caregiver) must sign and approve all documents including EVV attestation, Statement of Choice, POC and Acknowledgement
form indicating the recipient has been provided with "Recipient Rights Form", information about "Advance Directives" and "Preventative Care";
3. Must be enrolled through a waiver provider agency;
4. Must undergo Criminal Background Check;
5. Must be trained in assisting with Activities of Daily Living and meet requirements set forth by the state licensure agency, Bureau of Health
Care Quality and Compliance (HCQC).
6. Services must be authorized, and provision of services is in accordance with the Plan of Care as determined by the Case Manager and
recipient/designated rep;
7. Must utilize Electronic Visit Verification (EVV) system for check in/check out;
8. All claims must be submitted electronically and payments for services are paid directly to provider agency as the employer.

All claims must be submitted electronically via the Medicaid Management Information System (MMIS) aka Interchange, where the system has a built-in edit to map waiver services claims to provider type, recipient's eligibility code (designated waiver codes) and prior authorization.

Assurance that payments are made only for those authorized waiver services is through financial reviews conducted by DHCFP QA unit on an annual basis and DHCFP Surveillance Utilization Review (SUR) unit.

Additional safeguard assurance is through the Case Managers (CM) contact with recipients. CM will conduct at least one (1) face-to-face visit contact with the recipient annually. However, if the LRI is chosen by the recipient to provide paid personal care assistance, the case manager will conduct more frequent home visits (no less than bi-annually in person and quarterly via telephone) to ensure recipients are satisfied with the waiver services and caregiver (LRI).

To guard against self-referral of LRI during the POC development, the case manager will educate the recipient/LRI that the caregiver must be enrolled through a provider managed Personal Care Agency. The case manager will provide a Personal Care Representative (PCR) form to be signed by the recipient and designated PCR. The PCR cannot be the paid caregiver – this will also address "conflict of interest". The PCR is responsible for monitoring and signing off the provision of services by the caregiver (LRI, non LRI family member or non-family member).

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

○ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**

○ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

◉ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

Relatives, who are NOT legal guardians, may be paid for providing waiver services. Nevada's Legally Responsible Individual include spouses, legal guardians, and parent(s), stepparent(s), foster parent(s), and adoptive parent(s) of minor children.

Relatives must adhere to all waiver providers' requirements as stated in the FE Waiver Medicaid Services Manual (MSM) Chapter 2200, Section 2203.3B Provider Responsibilities and Intermediary Service Organization (ISO) MSM Chapter 2600 Section 2603.8 Provider Responsibilities. All relative caregivers are responsible to ensure they are in compliance with required training as a FE waiver provider, only provide services in accordance with the waiver recipient's service plan, and Plan of Care must be developed and signed by all applicable participants: recipient, relative caregiver and case manager. Additionally, all waiver services must be prior authorized prior to providing services; and, ISO entities are subject to DHCFP and ADSD Quality Assurance (QA) units' review, which is reported to CMS. Relative caregivers are treated equally to other PCA's which require all employees to have onsite records available for review. The employee file must contain the result of the criminal background check, training certificate(s). Each Waiver participant must have a file which contains the POC, which, if applicable, includes justification and narration to support why a recipient is unable to sign or initial required documentation. IF during during a QA review, it was determined that caregiver was non-compliant, the case is also referred to DHCFP Surveillance and Utilization Review (SUR), for further investigation and possible recoupment.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR § 431.51:

Any willing provider that meets the established criteria for a specific provider type may enroll with the DHCFP through their fiscal agent. Enrollment is continuously open for all potential waiver providers.

The fiscal agent website www.medicaid.nv.gov lists required documentation for applications to enroll in Medicaid as a waiver provider by specific service type. Supporting information is also available in the Medicaid Services Manuals on the DHCFP website dhcfp.nv.gov

g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act. Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one*:

- ○ **No, the state does not choose the option to provide HCBS in acute care hospitals.**
- ○ **Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions.** *By checking the boxes below, the state assures:*
  - ☐ **The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;**
  - ☐ **The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;**
  - ☐ **The HCBS must be identified in the individual's person-centered service plan; and**
  - ☐ **The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.**

And specify: **(a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting;(b) How the 1915(c) HCBS will assist the individual in returning to the community; and(c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.**

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of provider applicants that meet licensure/certification qualifications prior to delivering services. N: Number of provider applicants that meet licensure/certification qualifications prior to delivering services; D: Total number of provider applicants.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of currently enrolled providers, by type, initially and continue to meet licensure/certification qualifications. N: Number of currently enrolled providers, by type, initially and continue to meet licensure/certification qualifications; D: Total number of currently enrolled providers.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample**

		Confidence Interval = 95/5
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Every 24 months	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Every 24 months

b. ***Sub-Assurance: The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of non-licensed/non-certified provider applicants that meet qualifications prior to delivering services. N: Number of non-licensed/non-certified provider applicants that meet qualifications prior to delivering services; D: Total number of non-licensed/non-certified provider applicants.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: Fiscal Agent	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of currently enrolled non-licensed/non-certified providers that continue to meet qualifications. N: Number of currently enrolled non-licensed/non-certified providers that continue to meet qualifications; D: Total number of currently enrolled non-licensed/non-certified providers.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample**

		Confidence Interval = 95/5
☒ **Other** Specify: Fiscal Agent	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Every 24 months	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Every 24 months

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of agencies whose employees receive annual training as specified in policy and procedure. N: Number of agencies whose employees receive annual training as specified by policy and procedure; D: Number of agencies reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider reviews on-site

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level and +/- 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify:	

	Every 24 months, or more often if indicted	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Every 24 months, or more often if indicted

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The Fiscal Agent will not enroll any provider that does not meet Medicaid or waiver provider qualifications.

All providers under this waiver are licensed or certified with the State except PERS, Private Case Management Agencies and Home Delivered Meal providers.

DHCFP conducts annual program and fiscal reviews of services provided under this waiver. The annual review is structured as a look-back and includes review of provider qualifications to ensure ongoing compliance with waiver requirements. Additionally, the Bureau of Health Care Quality and Compliance (HCQC) conducts audits of all providers on a yearly basis for renewal of state licensure.

ADSD also performs annual provider reviews on all waiver providers. If problems are discovered during the review, staff takes appropriate action and provides education and training to the provider. An alert memo is forwarded to DCHFP and HCQC as indicated based on the identified based on the identified issue or deficiency notes. A Corrective Action Plan (CAP) may be required for remediation, or the provider may be suspended or terminated. The action taken depends on the nature of the problem and the action of the provider to correct and prevent recurrences of the problem.

HCQC also conducts investigations, and findings are reported to DHCFP Provider Enrollment Unit. Once DHCFP receives a referral for investigation, DHCFP Provider Enrollment Unit conducts a thorough provider investigation for further action including termination.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

During monthly contacts, a Case Manager may identify a situation where providers are not meeting requirements. The Case Manager will then address the concern with the provider. If a resolution cannot be reached, the Case Manager will refer the concern to the DHCFP fiscal agent to be addressed appropriately. Additionally, the recipient will be given the option of choosing a different provider of services if they so choose until resolution is achieved, the Case manager will follow up at the time of the next contact to ensure the issue remains resolved.

Training deficiencies are discussed during the quarterly QM meeting for possible remedial strategies, actions or additional training. ADSD QA is responsible for monitoring progress based on identified training deficiencies, and for reporting progress to DHCFP LTSS.

The results of DHCFP waiver reviews are used as the basis for discussion between DHCFP and ADSD to create a joint Plan of Improvement (POI) and monitored for progress at subsequent reviews by DHCFP. The ADSD quality management specialist monitors progress on the POI quarterly.

ADSD reviews a sampling of employee files during their annual visit as well. If a provider does not meet training criteria, the provider is notified of the deficiencies and a plan of improvement is required. DHCFP monitors progress on plans of improvement.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other**	☒ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 §§ CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings in which 1915(c) HCBS are recieved. *(Specify and describe the types of settings in which waiver services are received.)*

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)*

3. *By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:*

☐ **The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.**

☐ **The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in**

the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board. ***(see Appendix D-1-d-ii)***

☐ **Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.**

☐ **Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.**

☐ **Facilitates individual choice regarding services and supports, and who provides them.**

☐ **Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.**

Provider-owned or controlled residential settings. (*Specify whether the waiver includes provider-owned or controlled settings*.)

○ **No, the waiver does not include provider-owned or controlled settings.**

○ **Yes, the waiver includes provider-owned or controlled settings.** (By checking each box below, the state assures that each setting, *in addition to meeting the above requirements, will meet the following additional conditions*):

☐ **The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.**

☐ **Each individual has privacy in their sleeping or living unit:**

- ☐ **Units have entrance doors lockable by the individual.**
- ☐ **Only appropriate staff have keys to unit entrance doors.**
- ☐ **Individuals sharing units have a choice of roommates in that setting.**
- ☐ **Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.**

☐ **Individuals have the freedom and support to control their own schedules and activities.**

☐ **Individuals have access to food at any time.**

☐ **Individuals are able to have visitors of their choosing at any time.**

☐ **The setting is physically accessible to the individual.**

☐ **Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan*(see Appendix D-1-d-ii of this waiver application).***

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Person Centered Service Plan

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. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. *(Select each that applies):*

☐ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☒ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

☐ **Social Worker**
Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant. *Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:***

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a process in place to ensure:*

☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**

☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**

☐ **Direct oversight of the process or periodic evaluation by a state agency;**

☐ **Restriction of the entity that develops the person-centered service plan from providing services without**

the direct approval of the state; and

☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

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.

Qualified case managers develop the PCSP using the person-centered approach.

The Person-Centered approach includes involvement and choice by the recipient and/or designated representative to establish the frequency, scope, duration, and method of service delivery; is driven by the individual, designated representative, legal guardian, or other supports chosen by the individual; and includes necessary information and support to ensure that the individual directs the process to the maximum extent possible. The Case Manager guides the process by explaining the recipient’s rights and responsibilities, processes, requirements and provides information about the range of services and supports offered through the waiver, which allows the recipient to make informed choices, at the same time, addressing the health, welfare, and safety of the recipient.

Person Centered planning includes convenience to the recipient, cultural considerations, use of plain language, strategies for solving any disagreements, identification of what is important to and for the individual, personal preferences, choice of caregivers, strategies to facilitate health and welfare and remediate identified risks, identified goals, outcomes, preferences related to relationships, community integration and opportunities to participate in integrated settings, opportunities to seek employment or volunteer activities, control over personal resources.

The Statement of Choice (SOC) form is used to inform applicants of their rights and the right to choose between home and community-based waiver services or placement in an institutional setting and is signed by the recipient or designated representative. Additionally, the Recipient Rights form is reviewed with and provided to the recipient and or/designated representative which include choice of service provider and may request a change in services or service provider at any time.

A PCSP must be established for all actively approved recipients The PCSP includes, at a minimum, the individual's needs, goals to meet those needs, identified risks, services to be authorized under the Waiver, and non-waiver services. Case managers will assist the recipient in gaining access to necessary State Plan and Waiver services as well as needed medical, social, educational, and other services, regardless of funding sources.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. i. 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; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. 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):

Case managers develop the PCSP, in conjunction with the LOC and Social Health Assessment (SHA). The recipient and family members, support system and/or designated representative of the individual's choosing are encouraged to participate in the planning process. The PCSP is developed following the person-centered approach.

(a) Initial development of the PCSP and annual updates are completed by the Case Manager in conjunction with the recipient, designated representative, and/or person of their choosing. The PCSP is completed no more than 60 calendar days from waiver enrollment. The finalized PCSP must be signed and dated by the recipient acknowledging participation in the development of the PCSP. Ongoing PCSPs are updated and revised when there is a significant change expected to last more than 30 days that occurs outside of the annual review.

(b) The Case Manager completes the SHA which is used to assess the recipient's needs preferences and individualized goals. This assessment process includes addressing activities of daily living (ADLs), instrumental activities of daily living (IADLs), service needs, and support systems. In addition, this process includes gathering information regarding the health status, medical history and social needs. The PCSP process considers risk factors, equipment needs, behavioral status, current support system, and unmet service needs. A list of available waiver services is provided to the recipient and/or their representative. Development of the PCSP considers the recipient's location, availability of transportation, and necessary or desired activities to ensure preferences can be met. Personal goals are identified by the recipient and documented on the PCSP initially and each time the PCSP is updated.

(c) At the recipient's initial face to face visit with the Case Manager, the recipient is informed of services available through the waiver. An informational brochure is provided to the recipient describing these services.

(d) The recipient is an active participant the PCSP development process ensuring that participant goals, needs, and preferences are addressed through the inclusion of the recipient, involved family members, and personal representatives. Choice of service and providers are integrated in the planning process.

(e) The PCSP identifies the services required, including type, amount, duration, scope and frequency of services. Specific tasks, risk factors or direction are noted. The service providers are contacted to establish availability and are provided with a copy of the recipient's Service Plan prior to initiation of services. The assigned case manager reviews the document with the recipient and coordinates the initiation of services with the chosen provider.

(f) Contact with recipients is required to be initiated by the Case Manager to discuss the authorized services and evaluate the recipient's level of satisfaction. Contacts must be made to sufficiently verify that services are being provided appropriately or as outlined in the PCSP and identify changes in condition or service needs.
During contact or home visits, case managers are responsible to capture feedback from the recipient to help ensure services are delivered as authorized in the PCSP. Using the person-centered approach, case managers, applicants/recipients, family members, support system and designated representatives will determine the method and frequency of contacts. The case manager will assure that all recipients have appropriate case management on a case-by- case basis.

(g) The DHCFP QA uses a representative sample with a confidence interval equal to 95/5 of PCSPs retrospectively during the annual review of this waiver program or more frequently if necessary (in response to complaints or quality management concerns). The review is designed to assure that PCSPs are appropriate to the assessed needs of the recipient and ensure recipient health, safety, welfare, and ensure recipient choice of provider.

(h) The Waiver recipient participates in the development of the PCSP by participating in the SHA which is the tool used to determine the direction of the PCSP. Once the PCSP is created, it is reviewed with the Waiver recipient and anyone of their choosing including but not limited to their personal representative, LRI or person of their choice. Any modifications to the PCSP are discussed between the Case Manager and the recipient and the PCSP is revised accordingly. Once completed, the Case Manager and the Waiver recipient sign and date the PCSP affirming their acknowledgement and agreement.
During contact or home visits, case managers are responsible to capture feedback from the recipient to help ensure the PCSP remains relevant to the preferences, needs, health status and goals.

For those individuals who are already receiving State Plan PCS, the PCSP must indicate if the recipient is receiving State Plan PCS. This is needed to verify that waiver services are authorized in addition to the State Plan PCS hours to

support the individual's needs. The State has a requirement in place that all PCSPs must be finalized within 60 days from waiver enrollment.

ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

☐ **The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.**

☐ **For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:**

- ☐ **A specific and individualized assessed need for the modification.**
- ☐ **Positive interventions and supports used prior to any modifications to the person-centered service plan.**
- ☐ **Less intrusive methods of meeting the need that have been tried but did not work.**
- ☐ **A clear description of the condition that is directly proportionate to the specific assessed need.**
- ☐ **Regular collection and review of data to measure the ongoing effectiveness of the modification.**
- ☐ **Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.**
- ☐ **Informed consent of the individual.**
- ☐ **An assurance that interventions and supports will cause no harm to the individual.**

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

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.

Potential risks to recipients are assessed during the initial and annual 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 recipient's ability to manage medication, potential to wander, resist care, 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. Additional at risk criteria used and incorporated, as applicable, into the SHA, PCSP development, and service needs identification may include:

Access to medical services
Aggression/Behavioral problems
Aspiration/choking
Bedbound
Change in support/inconsistent
Chronic Health problems
Communication deficit
Crisis/emergency situation
Dementia/Alzheimer's/Cognitive Deficit
Difficulty/obtaining meals
Endagering self/self neglect
Endurance deficit
Environmental(cluttered/hoarding/maintenance/infestation/Sanitation)
Fall Risk/History of falls/unsteady gait
Finances
Illegal activities in home
Incontinent
Isolation
Lives alone
Loss of Medicaid and/or other medical insurance
Mental health issues
Multiple Emergency Rooms visits/Hospitalizations
Multiple Prescriptions
Non-compliance to medication/treatment
Non-cooperation
Nutritional/special diet
Other-specify in notes
Oxygen
Physically/verbally abusive
Requires minimal essential PCS/NRS 426.723
Resistive to care
Rural area with limited resources
Safety Risk
Seizures
Sensory deficits
Service needs exceed available resources
Service Refusal
Sexual Behavior
Shopping Difficulty/food/prescriptions
Skin breakdown/wounds
Smoking
Socially inappropriate
Substance Abuse
Terminal Illness
Unavailable LRI/Caregiver
Victim of abuse/neglect/isolation/exploitation-
Wandering

Risks are identified on the SHA. Some risks are mitigated by the implementation of services through State Plan and/or

waiver services and other resources. Some risks are addressed but not necessarily mitigated due to recipient choice. For example, smoking is a risk, but a recipient has that choice. Case manager's document identified risks and how they are addressed within the recipient SHA to include formal and informal supports in place for risk mitigation. Recipients have a choice of providers. Providers are required to provide a back-up plan.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

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.

The Statement of Choice form is used to inform new waiver applicants and ongoing recipients of their right to choose a provider. In addition, the applicant/recipient is notified of their right to choose HCBS in their home or in a residential setting instead of an institutional setting. A brochure is provided to the applicant describing available services. The case manager works with the applicant/recipient to ensure that individualized preferences are maintained. If a service provider change is requested or a new service need identified, the case manager will coordinate and update the POC and authorizations as indicated.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

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):

DHCFP reviews a representative sample of POCs retrospectively during the annual review of this waiver program or more frequently if necessary (in response to complaints or quality management concerns). The review is designed to assure that POCs are appropriate to the assessed needs of the recipient, ensure recipient health, safety, welfare, and are given the choice of providers.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update, when the individual's circumstances or needs change significantly, or at the request of the individual, to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. 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 § 92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☐ **Operating agency**

☒ **Case manager**

☐ **Other**
Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: 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, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

a) The assigned case manager is responsible for monitoring the implementation of the Plan of Care (POC) and recipient's health and welfare. This is accomplished through the case manager's person-centered contacts and annual face-to-face visits. Additional monitoring of recipient's health and welfare is done by DHCFP and ADSD Quality Assurance (QA).

b) The POC is monitored and reviewed/revised through a face-to-face annual re-assessment or when the recipient has a significant change lasting longer than 30 days. The POC is reviewed for the following:
1. Personal/individualized goals (if the recipient is unable to provide personal goals, the case manager will collaborate with the family or designated representative to establish goal(s) to benefit the recipient. The goal(s) is documented in the POC.
2. Specific waiver and non-waiver services that have been identified and/or authorized as a need for the recipient;
3. The proposed frequency, duration, scope and type of provider for each service is identified and/or authorized.
4. Signature by the recipient and/or designated representative that they participated in POC development (SOC/Addendum); and
5. Recipient's risks are identified and include discussion of back-up plans to mitigate risks.

In addition to the annual re-assessment monitoring, ongoing contact with recipients are conducted using the person-centered approach, the recipient is given the option for the frequency and method of ongoing contact that is sufficient to meet the needs of the recipient. The purpose of the ongoing contact is to follow-up and addresses with recipients the following: recipient's satisfaction of services and providers, any unmet or additional service needs, the health and welfare of recipients, any changes in medical condition, changes in goals or if goals are met, reviews with recipient or designated representative changes in support network including back-up plan in the event that no provider can render services to remain in the community. The amount of case management services must be adequately documented and substantiated by the case manager's notes.

Further, to assure the health, safety and welfare of recipients and assessment, on a continual basis, of recipients' satisfaction with services, DHCFP and ADSD Quality Assurance (QA) administer the Participant Experience Survey (PES) which is completed during a visit to the recipient's home or by telephone. Any negative response from recipient is sent to the case manager to address the concern/issue. Results of the PES and follow-up actions taken by the case managers (if any) are then reported to DHCFP LTSS for review and reporting to CMS via 372 report.

During the Case Manager's assessment, re-assessment and ongoing contact, appropriate referrals and follow-ups are made as needed.

c) Case managers must, at a minimum, complete one annual face-to-face visit with the recipient, and using the person-centered approach, the recipient is given the option for the frequency and method of ongoing contact that is sufficient to meet the needs of the recipient. The amount of case management services must be adequately documented and substantiated by the case manager's notes.

Case manager encourages recipient's family, support system and/or a designated representative, or members of the recipient's support system to attend face-to-face visits with the recipient in reviewing, changes or updates to the POC (if applicable) and concerns (if any) with service providers. Family members, a designated representative, or a member of the recipient's support system assist recipients who have cognitive or communication difficulties.

Case management agencies are required to review a representative sample of cases monthly. DHCFP collects data on the findings of their reviews, the actions taken, and the effectiveness of those actions. Case management provider agencies are required to participate in DHCFP's annual audit. At the discretion of the Medicaid Agency, and based on the findings, an additional sample size may be requested to ensure compliance with the measures set in this Waiver.

b. Monitoring Safeguards. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**
- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the**

participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation. *(Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation).*

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. *By checking each box, the state attests to having a process in place to ensure:*

- ☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**
- ☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**
- ☐ **Direct oversight of the process or periodic evaluation by a state agency;**
- ☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**
- ☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participantsï?½ assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of recipients POCs that include personalized goals. N: Number of recipients POCs that include personalized goals; D: Number of recipient POCs reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level and +/- 5% margin of error
☒ **Other** Specify: Case management provider	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of recipients POCs that address the assessed needs identified in the social health assessment (SHA). N: Number of recipients POCs that address te assessed needs identified in the SHA; D: Number of recipients POCs reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level and +/- 5% margin of error
☒ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

Case management provider		
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of recipients POCs that address health and safety risk factors.
N: Number of recipients POCs that address health and safety risk factors; D: Number of recipient POCs reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for	**Frequency of data**	**Sampling Approach**

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level and +/- 5% margin of error
☒ **Other** Specify: Case management provider	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of recipients POCs that are revised annually. N: Number of recipients POCs that are revised annually. D: Number of recipients POCs reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data	**Frequency of data collection/generation**	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*	*(check each that applies):*	
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level and +/- 5% margin of error
☒ **Other** Specify: Case management Provider	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of recipients POCs that are updated when the participants needs changed. N: Number of recipients POCs that are updated when the participants needs changed. D: Number of recipients POCs reviewed where there was a documented change in need.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level and +/- 5% margin of error
☒ **Other** Specify: Case management provider	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and**	☐ **Other**

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Participants are afforded choice between/among waiver services and providers.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of recipients services that are delivered in accordance with the approved POC. N: Number of recipients whose services are delivered in accordance with the approved POC. D: Number of recipients records reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level and +/- 5% margin of error
☒ **Other** Specify: Case Management Provider	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of recipients who indicate during contacts that they are receiving the services they need. N: Number of recipients who indicate they are receiving the services they need. D: Number of recipients records reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level and +/- 5% margin of error

☒ **Other** Specify: Case Management Provider	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: The state monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-

assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of recipients whose SOC is signed indicating choice providers and choice of services. N: Number of recipients whose SOC is signed indicating choice of providers and choice of services. D: Number of recipient records reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level and +/- 5% margin of error
☒ **Other** Specify: Case Management Provider	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Case management supervisors review a sample size of ongoing case files producing a probability of 95% confidence level with a +/- 5 confidence interval.

DHCFP conducts annual program and fiscal reviews of services provided under this waiver. A sample size producing a probability of a 95/5 percent confidence level is utilized. The annual review is structured as a lookback review of all delegated functions and confirmation of quarterly data on performance measures provided by the Case Management provider. DHCFP has the ability to break out the findings by the specific policy area. During the review, DHCFP staff evaluates compliance with policies related to the operation of the waiver and assure such policies are administered correctly. Policies are available on DHCFP's website, https:\\dhcfp.nv.gov, and it is the responsibility of Case Management providers to stay abreast with the current policy to ensure proper delivery of service is in accordance with the waiver.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Case Management provider supervisory staff reviews the POC to assure that service needs, health and safety risk factors, and personal goals are identified and incorporated into the POC. If these areas are omitted or incorrect, supervisors address this individually with Case Managers and corrections are made immediately.

Case File Reviews are submitted by the Case Management Provider to DHCFP QA as they are completed for entry into a database which will analyze data to identify areas needing improvement, trends and training opportunities. The results are reported at the quarterly QI meetings for recommendations, remedial action, and improvement strategies.

The Case Manager ensures that the services on the POC are assigned the appropriate prior authorization. A copy of the Service Plan is given to the servicing provider. The Case Manager provides care instructions to the servicing provider. The servicing provider must bill and receive payment through MMIS.

Case Managers use a SOC form to indicate the recipient's acknowledgment of their right to choose home and community based services in their home, as opposed to placement in a nursing facility, and the provider of their choice. Case Managers inform recipients of their right of choice at the time of initial assessment and during ongoing recipient contacts.

DHCFP QA and ADSD QA complete annual Participant Experience Surveys (PES) using a 95/5 Confidence Interval sampling of ongoing Waiver recipients which include questions on choice and satisfaction. PES are submitted to DHCFP QA on an ongoing basis to be analyzed for trends and areas of improvement. The information is discussed at the quarterly QI meetings to identify areas for improvement and develop remedial strategies.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified

strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- ○ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ◉ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR ?431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Medicaid Services Manual (MSM) Chapters 2200, Waiver for Frail Elderly, 3100, Hearings, identifies the following circumstances under which Notice of Decision (NOD) must be made to a waiver participant or participant of an adverse action:

- Denial of waiver participation
- Termination of waiver services
- Reduction of waiver services
- Suspension of waiver services

When an applicant is issued a Notice of Decision (NOD) indicating that the request for service(s)/provider(s) has been denied, the NOD additionally provides information to the applicant on how to request a fair hearing if they do not agree with the decision.

The following language is included on the NOD:

If you disagree with Medicaid's denial, reduction, suspension or termination of service, you may request a Fair Hearing. A Fair Hearing allows you and Medicaid to give information about your situation to a Hearing Officer. The Hearing Officer is a neutral party who makes a decision on your appeal. There is no charge for a Fair Hearing.

Medicaid must receive your request within 90 calendar days from the Notice Date.

You may represent yourself or have the help of another adult. The adult can be a friend, family member, or lawyer. Medicaid has provided the names of some agencies that may be able to help you. (See below).

The request for a Fair Hearing must include: (1) your name, address, telephone number (2) Medicaid number; and (3) if someone is helping you, the name, telephone number and address of the adult who will help you (the "authorized representative"). You must sign the request unless you are unable to do so because of your disability. You may use the enclosed form to request a Fair Hearing.

If you want your services to stay the same during the Fair Hearing process, you must: 1) ask for a hearing not more than 10 calendar days after the Date of Action (shown on the Notice of Decision); and 2) you must ask that your services stay the same. (During the Fair Hearing process, your services will be continued). You may use the enclosed form to do this.

You may request a Fair Hearing to be expedited because a standard hearing could jeopardize your life, health, or ability to attain, maintain or regain maximum function. Documentation from your medical provider to support this request must be included. (If documentation is not supplied, the request will be processed within the standard Fair Hearing timeframe of 90 days).

Medicaid may ask you to pay back the cost of the continued services if you lose your appeal.

After you have requested a Fair Hearing, Medicaid will contact you within 10 days to arrange a Hearing Preparation Meeting (HPM). The meeting will be by telephone. The goal of this meeting is to try to resolve your appeal. Medicaid will explain its decision and give you the chance to provide more information. If you and Medicaid cannot agree, you may go to a Fair Hearing. A Hearing Preparation Meeting (HPM) is optional. You do not have to take part in a HPM. You can let Medicaid know you want to go directly to a Fair Hearing and have a Hearing Officer decide your appeal.

To find out more about Medicaid appeals, you may go to the Nevada Department of Health and Human Services, Division of Health Care Financing & Policy's Medicaid Service Manual Chapter 3100 – Hearings at: https://dhcfp.nv.gov

DHCFP has a separate hearings unit located at Central Office. All waiver hearing requests are directed to that unit and are assigned out to a hearings representative. All hearing requests and outcomes are kept within a hearings database.

In addition, the SOC, which is signed prior to service delivery, includes the following statements:

I may request a hearing from the Division of Health Care Financing and Policy (DHCFP) if I have not been given a choice of Home and Community-Based Services as an alternative to a long-term-care facility placement, if I am denied this service, or if services are reduced, suspended or terminated. A written request for a hearing must be sent to DHCFP, 1100 E. William Street, Suite 102, Carson City, NV 89701, within 90 calendar days from the Notice of Decision date.

The assigned Case Manager reviews the SOC with the recipient at the time of initial assessment. The recipient and/or designated representative/LRI is provided a copy of the signed SOC. The ongoing Case Manager will maintain a copy of adverse actions

that result in a hearings request. All documentation related to a hearing and/or hearing request is maintained by the DHCFP Hearings Unit.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

◉ **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*

○ **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Nevada Revised Statutes (NRS) Reads as follows: NRS 200.5091 Policy of State. It is the policy of this State to provide for the cooperation of law enforcement officials, courts of competent jurisdiction and all appropriate state agencies providing human services in identifying the abuse, neglect, exploitation, isolation and abandonment of older persons and vulnerable persons through the complete reporting of abuse, neglect, exploitation, isolation and abandonment of older persons and vulnerable persons.

The statute includes an extensive list of persons required to report incidences of abuse, neglect, exploitation, isolation or abandonment, which includes persons who provide medical or social services or supports.

The report must be made to a law enforcement agency as soon as reasonably practicable, but not later than 24 hours after the person knows or has reasonable cause to believe that an older person or vulnerable person has been abused, neglected, exploited, isolated or abandoned. Because of these timeframes, telephone or facsimile reports are accepted by most law enforcement agencies.

DHCFP requires all direct care providers for the Waiver to report all serious occurrences including falls and injuries requiring medical attention, deaths, unplanned hospital visits, loss of contact, theft. Any incidents of suspected abuse, neglect, exploitation, isolation, or abandonment reported to the ADSD Adult Protective Services (APS) and/or law enforcement will be reported to DHCFP LTSS in real-time for tracking. On a quarterly basis, DHCFP LTSS will be requesting outcomes of the investigations from APS and and documentation of actions taken by the Case Manager.

Reporting of SOR can be in paper form or electronic format which is accessible to all providers, public and State staff via the DHCFP's public website and the DHCFP Fiscal Agent's website. The process for reporting incidents will depend on who is providing the case management services to the particular recipient. The direct waiver service providers are responsible to know who the Case Manager is and the proper form of submission.

Due to the different databases utilized by public and private CM, the processes for submitting SOR are as follows:

ADSD Case Management SOR Database - The SOR Database is used by the ADSD Case Managers to receive reports, track outcomes and provide data to the DHCFP LTSS. Providers, the public and ADSD is able to access this database on the DHCFP public website as well as the DHCFP Fiscal Agent website. When a SOR is completed and submitted through the portal, it will alert the ADSD Case Manager. The Case Manager will review the information, contact the recipient or reporting party and provide necessary follow-up to ensure the health, safety and welfare of the recipient. Once the SOR is considered closed, the database is updated, and it is reviewed by the Case Managers supervisor for accuracy. If the Supervisor determines additional follow-up is required, they will communicate this to the Case Manager. If the Supervisor determines the outcome was appropriate, it will be considered closed. The ADSD QA unit will conduct a 95/5 Confidence Interval sample of closed SOR's to determine appropriates, and report this data to the DHCFP LTSS for analysis and reporting.

Private Case Management SOR database is not available through public facing DHCFP website; therefore, any incident report for a recipient receiving PCM must be submitted in paper form to DHCFP LTSS inbox at hcbs@dhcfp.nv.gov. Paper form will be re-routed to PCM who will enter the SOR in their database and perform the necessary follow-up. PCM will provide a report to DHCFP on a quarterly basis or upon request.

The State of Nevada has established mandatory reporting requirements of suspected incidents of abuse. ADSD APS and local Law Enforcement are the receivers of such reports. Reports must be made within 24 hours of discovery, identification and/or suspicion. A completed SOR submitted by a Waiver provider must be made within five (5) working days and maintained in the recipient's case file. The Case Manager will have five (5) working days to follow up with the recipient and/or provider on the critical event. The Case Managers and waiver providers are mandated reporters.

Recipient safeguards include initiation of investigation by local law enforcement and/or APS, and provision of protective services to the older and vulnerable persons if the recipient is able and willing to accept them. If the person who is reported to have abused, neglected, exploited, isolated or abandoned an older person or a vulnerable person is the holder of a license or certificate issued pursuant to NRS Chapters 449, 630 to 641B, inclusive, or 654, information contained in the report may be submitted to the Board that issued the license.

The Division of Public and Behavioral Health (DPBH) receives complaints regarding the entities they license.

Enrolled waiver providers are required to report concerns with care supervision and delivery to the Case Manager under their current contracting language. Reporting includes:

1. Suspected physical or verbal abuse;
2. Unplanned hospitalization;
3. Abuse, neglect, exploitation, isolation, abandonment, or unexpected death of the recipient;
4. Theft;
5. Sexual harassment or sexual abuse;
6. Injuries requiring medical intervention;
7. An unsafe working environment;
8. Any event which is reported to Adult Protective Services (ages 18 years old and above) or law enforcement agencies;
9. Death of the recipient;
10. Loss of contact with the recipient for three (3) consecutive scheduled days or;
11. Medication errors resulting in injury, hospitalization, medical treatment or death.
12. Elopement of a recipient residing in a Residential Facility for Groups;

Case Managers will be notified of any serious occurrence within 24 hours of discovery. Case managers will have five (5) working days to follow up with the recipient and/or provider on the critical event. 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 recipient will be offered protective services as appropriate. Serious occurrences will be forwarded to ADSD for recipients with public case management or DHCFP for recipients who have chosen a private case management agency. The trends of the reports will be reviewed at the Quarterly QI and program/policy modifications will be recommended if possible.

Instances of abuse, neglect, exploitation, isolation or abandonment alleged to be committed by a Medicaid provider must have an internal investigation by the provider. The provider must provide the final results to the DHCFP of how they have addressed the problem.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Case managers educate clients regarding reporting requirements and available agency contacts.

Annually-Recipient Rights form is reviewed with and provided to the participant/guardian/family during the in-person assessment and reassessment. The Statement of Choice is maintained in the recipient’s case file which includes a signature acknowledging they received and understand the Recipient Rights form.

The Recipient Rights form includes phone numbers of various agencies and other additional resources on how to report abuse, neglect, and exploitation. The information page is reviewed annually during the reassessment process/annual face-to-face home visit. This information page also includes the names and phone numbers of both the assigned case manager and the case manager supervisor.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Reports of abuse, neglect, exploitation, isolation, or abandonment of older and vulnerable persons are made to ADSD APS Unit. Reports are investigated by APS within three (3) working days of receipt. Investigations are confidential; however, APS does provide the disposition of completed investigations upon request of the DHCFP LTSS unit. If an individual wants the results of an investigation, they must contact APS directly for this information. APS informs recipients and their designees of how to contact them during and after the investigation.

For reports outside normal working hours, reports are made to law enforcement. Law enforcement agencies are required to investigate reports of abuse, neglect, exploitation, isolation, or abandonment immediately.

To ensure the health and welfare of waiver recipients, waiver providers are required to report all serious occurrences to the Case Management provider. The Case Manager reviews the SOR and determines whether immediate response is necessary, and if so, responds immediately. The Case Manager contacts the recipient, determines confidentiality, verifies the information in the SOR, and takes appropriate action. Case management supervisory staff reviews the adequacy and effectiveness of the case manager's response to reports. If requested by the recipient or representative, results of the SOR investigation can be provided.

Instances of abuse, neglect, exploitation, isolation or abandonment alleged to be committed by a Medicaid provider must have an internal investigation by the provider. The provider does provide the final results to the appropriate State agency of how they have addressed the problem.

If the case is sent to Adult Protective Services (APS) for investigation and the individual wants the results of the investigation, they must contact APS directly for this information. APS informs recipients and their designees of how to contact them during and after the investigation.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Case Management agency is responsible for overseeing the reporting of and response to critical incidents or events as well as timely follow up and remediation if indicated. The number and type of events received by providers are entered into a database and summary reports are produced by type and by provider for review of trends and issues on a quarterly basis.

ADSD or DHCFP depending on the case management provider for the recipient, maintains, monitors, evaluates the follows-up on SORs. The report for ADSD SOR’s is compiled by ADSD QA and submitted to DHCFP LTSS on a quarterly basis and upon request. DHCFP LTSS collects the data for the Private Case Management SORs.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◉ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The Case Management providers, DHCFP QA and the ADSD QA are responsible for detecting the unauthorized use of restraints or seclusion. This is accomplished through ongoing person-centered contacts with waiver recipients, annual PES, and scheduled residential setting visits and reviews. The recipient is provided the phone number of their Case Manager, and their Case Managers supervisor, and has been advised to call if there are any problems or concerns. The Case Manager will assess any reported incidents of restraints or seclusion, and call the appropriate authorities, if applicable. The recipient is provided the contact information for APS and local law enforcement when they sign and receive a copy of the Recipients Rights form.

If any occurrence of unauthorized use of restraints or seclusion is assumed or detected, a report is made to the appropriate entity who will conduct appropriate follow-up and resolution.

Additionally, the annual program reviews of a representative sample help to detect and remediate any systemic issues regarding restraints and seclusions.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The Case Management providers, DHCFP QA and the ADSD QA is responsible for detecting the unauthorized use of restrictive interventions. This is accomplished through ongoing person-centered contacts with waiver recipients, annual PES, and scheduled residential setting visits and reviews. The recipient is provided the phone number of their Case Manager, and their Case Managers supervisor, and has been advised to call if there are any problems or concerns. The Case Manager will assess any reported incidents of restrictive interventions, and call the appropriate authorities, if applicable. The recipient is provided the contact information for APS and local law enforcement when they sign and receive a copy of the Recipients Rights form.

If any occurrence of unauthorized use of restrictive interventions is assumed or detected, a report is made to the appropriate entity who will conduct appropriate follow-up and resolution.

Additionally, the annual program reviews of a representative sample help to detect and remediate any systemic issues regarding restraints and restrictive interventions.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The Case Management providers, DHCFP QA and the ADSD QA is responsible for detecting the unauthorized use of seclusion. This is accomplished through ongoing person-centered contacts with waiver recipients, annual PES, and scheduled residential setting visits and reviews. The recipient is provided the phone number of their Case Manager, and their Case Managers supervisor, and has been advised to call if there are any problems or concerns. The Case Manager will assess any reported incidents of seclusion, and call the appropriate authorities, if applicable. The recipient is provided the contact information for APS and local law enforcement when they sign and receive a copy of the Recipients Rights form.

If any occurrence of unauthorized use of seclusion is assumed or detected, a report is made to the appropriate entity who will conduct appropriate follow-up and resolution.

Additionally, the annual program reviews of a representative sample help to detect and remediate any systemic issues regarding use of seclusion.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

○ **No. This Appendix is not applicable** *(do not complete the remaining items)*

◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The Bureau of Health Care Quality and Compliance (HCQC) monitors medication management activities for residential facilities for groups as described in the following Nevada Administrative Code (NAC):

NAC 449.2744 Administration of medication: Maintenance and contents of logs and records.
1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall maintain:
(a) A log for each medication received by the facility for use by a resident of the facility. The log must include:
(1) The type and quantity of medication received by the facility;
(2) The date of its delivery;
(3) The name of the person who accepted the delivery;
(4) The name of the resident for whom the medication is prescribed; and
(5) The date on which any unused medication is removed from the facility or destroyed. (b)A record of the medication administered to each resident. The record must include:
(1) The type of medication administered;
(2) The date and time that the medication was administered;
(3) The date and time that a resident refuses, or otherwise misses, an administration of medication; and
(4)Instructions for administering the medication to the resident that reflect each current order or prescription of the resident's physician.
2. The administrator of the facility shall keep a log of caregivers assigned to administer medications that indicates the shifts during which each caregiver was responsible for assisting in the administration of medication to a resident. This requirement may be met by including on a resident's medication sheet an indication of who assisted the resident in the administration of the medication, if the caregiver can be identified from this indication

NAC449.2742 Administration of medication: Responsibilities of administrator, caregivers and employees of facility. (NRS 449.0302)
1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall:
(a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility:
(1) Reviews for accuracy and appropriateness, at least once every 6 months, the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident; and
(2) Provides a written report of that review to the administrator of the facility.
(b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in the file maintained pursuant to NAC 449.2749 for the resident who is the subject of the report.
(c) Make and maintain a report of any actions that are taken by the caregivers employed by the facility in response to a report submitted pursuant to paragraph (a).
(d) Develop and maintain a plan for managing the administration of medications at the residential facility, including, without limitation:
(1) Preventing the use of outdated, damaged or contaminated medications;
(2) Managing the medications for each resident in a manner which ensures that any prescription medications, over-the-counter medications and nutritional supplements are ordered, filled and refilled in a timely manner to avoid missed dosages;
(3) Verifying that orders for medications have been accurately transcribed in the record of the medication administered to each resident in accordance with NAC 449.2744;
(4) Monitoring the administration of medications and the effective use of the records of the medication administered to each resident;
(5) Ensuring that each caregiver who administers a medication is in compliance with the requirements of subsection 6 of NRS 449.0302 and NAC 449.196;
(6) Ensuring that each caregiver who administers a medication is adequately supervised; (7)Communicating routinely with the prescribing physician or other physician of the resident concerning
issues or observations relating to the administration of the medication; and
(8)Maintaining reference materials relating to medications at the residential facility, including, without limitation, a current drug guide or medication handbook, which must not be more than 2 years old or providing access to websites on the Internet which provide reliable information concerning medications.
(e) Develop and maintain a training program for caregivers of the residential facility who administer medication to residents, including, without limitation, an initial orientation on the plan for managing medications at the facility for each new caregiver and an annual training update on the plan. The administrator shall maintain

documentation concerning the provision of the training program and the attendance of caregivers.
(f) In his or her first year of employment as an administrator of the residential facility, receive, from a program approved by the Bureau, at least 16 hours of training in the management of medication consisting of not less than 12 hours of classroom training and not less than 4 hours of practical training and obtain a certificate acknowledging completion of such training.
(g) After receiving the initial training required by paragraph (f), receive annually at least 8 hours of training in the management of medication and provide the residential facility with satisfactory evidence of the content of the training and his or her attendance at the training.
(h) Annually pass an examination relating to the management of medication approved by the Bureau.
2. Within 72 hours after the administrator of the facility receives a report submitted pursuant to paragraph (a) of subsection 1, a member of the staff of the facility shall notify the resident's physician of any concerns noted by the person who submitted the report. The report must be reviewed and initialed by the administrator.
3. Before assisting a resident in the administration of any medication, including, without limitation, any over-the-counter medication or dietary supplement, a caregiver must obtain written information describing the side effects, possible adverse reactions, contraindications and toxicity of the medication.
4. Except as otherwise provided in this subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.0302 are met.
5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744.
6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident:
(a) The caregiver responsible for assisting in the administration of the medication shall:
(1) Comply with the order;
(2) Indicate on the container of the medication that a change has occurred; and
(3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744;
(b)Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and
(c)If the label prepared by a pharmacist does not match the order or prescription written by a physician, the physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744.
7. If a resident refuses, or otherwise misses, an administration of medication, a physician must be notified within 12 hours after the dose is refused or missed.
8. An employee of a residential facility shall not draw medication into a syringe or administer an injection unless authorized by law to do so.
9. If the medication of a resident is discontinued, the expiration date of the medication of a resident has passed, or a resident who has been discharged from the facility does not claim the medication, an employee of a residential facility shall destroy the medication, by an acceptable method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449.2744.
10. The administrator of a facility is responsible for any assistance provided to a resident of the residential facility in the administration of medication, including, without limitation, ensuring that all medication is administered in accordance with the provisions of this section.

Each facility shall have and implement policies and procedures that minimize errors in the administration of drugs. The medical director of the facility and the pharmacist who is responsible for the pharmacy service shall approve the policies and procedures.

Errors in administering a drug, adverse reactions by a client to a drug and incompatibilities between a drug and a client must be immediately reported to the attending physician of the client.

If an accident or incident occurs at a facility, including, without limitation, any error in providing medication to a

patient of the facility or any adverse reaction of a patient to a drug administered to the patient at the facility, the facility shall immediately prepare a written record of the accident or incident. A written record prepared pursuant to this subsection must be maintained by the facility and be made available for review by the HCQC.

Additionally, medication errors resulting in injury, hospitalization, medical treatment or death would require that the incident is reported to the Case Manager within 24 hours from the date of discovery, and a SOR be submitted to the Case Management provider within five (5) business days. The Case Manager will follow up within five (5) business days from the date the SOR was submitted, and the Case Manager's supervisor will review the findings for appropriateness.

Medication management is not a component of a waiver service. Case Managers review medication logs for all Waiver recipients residing in a Residential Facility for Groups. If a medication issue is identified in a private home setting the recipient's Primary Physician is notified with a possible Home Health referral. In addition, all medication errors are sent to HCQC via an Alert memo. All entities work together to ensure remediation efforts are taken when necessary.
This may include a referral to the ADSD APS or Long Term Care Ombudsman to ensure health, safety and welfare of the Waiver recipient.

- All enrolled Waiver Providers are required to self-report medication errors.
- Case Managers check medication logs during in person contacts and as reported to ADSD or DHCFP who follows-up within 5 working days.
- Recipients may report missed doses or other issues to their Case Manager.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

HCQC is responsible for oversight and follow up of medication management for providers licensed as a Residential Facility for Groups. The Case Management or Quality Assurance staff review medication logs and notify HCQC in the form of an Alert Memorandum if issues are identified.

a) and b) NAC 449.2738 Review of medical condition of resident; relocation or transfer of resident having certain medical needs or conditions. (NRS 449.0302)

1. If, after conducting an inspection or investigation of a residential facility, the Bureau determines that it is necessary to review the medical condition of a resident, the Bureau shall inform the administrator of the facility of the need for the review and the information the facility is required to submit to the Bureau to assist in the performance of the review. The administrator shall, within a period prescribed by the Bureau, provide to the Bureau:
(a) The assessments made by physicians concerning the physical and mental condition of the resident; and
(b) Copies of prescriptions for medication or orders of physicians for services or equipment necessary to provide care for the resident.
2. If the Bureau or the resident's physician determines that the facility is prohibited from caring for the resident pursuant to NAC 449.271 to 449.2734, inclusive, or is unable to care for the resident in the proper manner, the administrator of the facility must be notified of that determination. Upon receipt of such a notification, the administrator shall, within a period prescribed by the Bureau, submit a plan to the Bureau for the safe and appropriate relocation of the resident pursuant to NRS 449.700 to a place where the proper care will be provided.
3. If an inspection or investigation reveals that the conditions at a residential facility may immediately jeopardize the health and safety of a resident, the administrator of the facility shall, as soon as practicable, ensure that the resident is transferred to a facility which is capable of properly providing for his care.

NAC449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medications for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself or herself without supervision may keep the resident’s medication in his or her room if the medication is kept in a locked container for which the facility has been provided a key.
2. Medication stored in a refrigerator, including, without limitation, any over-the-counter medication, must be kept in a locked box unless the refrigerator is locked or is located in a locked room.
3. Medication, including, without limitation, any over-the-counter medication or dietary supplement, must be:
(a)Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name of the prescribing physician; and
(b)Kept in its original container until it is administered.
4. Except as otherwise provided in subsection 5, when a resident is discharged or transferred from a residential facility, all medications prescribed for the resident must be provided to the resident or to the facility to which he or she is transferred.
5. If a resident is transferred to a hospital or skilled nursing facility, the residential facility shall hold the resident’s medications until the resident returns or for 30 days after the transfer, whichever is less, unless the hospital or skilled nursing facility requests the residential facility to provide the hospital or skilled nursing facility with the medications. If the resident does not return within 30 days after the transfer, the residential facility shall promptly dispose of any remaining medications. Upon the return of the resident from the hospital or skilled nursing facility, the residential facility shall, if there has been any change in the resident’s medication regimen:
(a) Contact a physician, within 24 hours after the resident returns, to clarify the change; and
(b) Document the physician contact in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744.

c) Medication administration is regulated by HCQC. If a resident refuses, or otherwise misses, an administration of medication, a physician must be notified within 12 hours after the dose is refused or missed.

Each facility shall have and implement policies and procedures that minimize errors in the administration of drugs. The medical director of the facility and the pharmacist who is responsible for the pharmacy service shall

approve the policies and procedures.

Errors in administering a drug, adverse reactions by a client to a drug and incompatibilities between a drug and a client must be immediately reported to the attending physician of the client.

If an accident or incident occurs at a facility, including, without limitation, any error in providing medication to a patient of the facility or any adverse reaction of a patient to a drug administered to the patient at the facility, the facility shall immediately prepare a written record of the accident or incident. A written record prepared pursuant to this subsection must be maintained by the facility and be made available for review by the HCQC.

To be licensed as a Residential Facility for Groups, caregivers and owners are required to obtain 16 hours of training in medication management consisting of not less than 12 hours of classroom training and not less than 4 hours of practical training and must obtain a certificate of completion.

Additionally, medication errors resulting in injury, hospitalization, medical treatment or death would require that the incident is reported to the Case Manager within 24 hours from the date of discovery, and a SOR be submitted to the Case Management provider within five (5) business days. The Case Manager will follow up within five (5) business days from the date the SOR was submitted, and the Case Manager's supervisor will review the findings for appropriateness.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

○ **Not applicable.** *(do not complete the remaining items)*

◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

See answers above. All residential group homes who are waiver providers must be licensed by HCQC and must follow the Nevada Administrative Code (NAC) as noted.

iii. Medication Error Reporting. *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

Providers are responsible to report medication errors to HCQC.

Each facility shall have and implement policies and procedures that minimize errors in the administration of drugs. The medical director of the facility and the pharmacist who is responsible for the pharmacy service shall approve the policies and procedures.

Errors in administering a drug, adverse reactions by a client to a drug and incompatibilities between a drug and a client must be immediately reported to the attending physician of the client.

If an accident or incident occurs at a facility, including, without limitation, any error in providing medication to a patient of the facility or any adverse reaction of a patient to a drug administered to the patient at the facility, the facility shall immediately prepare a written record of the accident or incident. A written record prepared pursuant to this subsection must be maintained by the facility and be made available for review by the HCQC.

Additionally, medication errors resulting in injury, hospitalization, medical treatment or death would require that the incident is reported to the Case Manager within 24 hours from the date of discovery, and a SOR be submitted to the Case Management provider within five (5) business days. The Case Manager will follow up within five (5) business days from the date the SOR was submitted, and the Case Manager's supervisor will review the findings for appropriateness.

(b) Specify the types of medication errors that providers are required to *record:*

Providers are responsible to record all medication errors.

(c) Specify the types of medication errors that providers must *report* to the state:

Provider are responsible to self report all medication errors to HCQC.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

HCQC has oversight of medication management. They investigate all complaints and conduct ongoing monitoring every 12-18 months.

Residential Facilities for Groups staff that meet qualifications to provide oversight and have had the training required to participate in medication administration provide medication management.

Training requirements are part of the NAC:

Administrators and caregivers of the residential facility, receive, from a program approved by the Bureau, at least 16 hours of training in the management of medication consisting of not less than 12 hours of classroom training and not less than 4 hours of practical training and obtain a certificate acknowledging completion of such training.

After receiving the initial training required, they must receive annually at least 8 hours of training in the management of medication and provide the residential facility with satisfactory evidence of the content of the training and his or her attendance at the training.

Annually pass an examination relating to the management of medication approved by the Bureau.

Administrators have to complete initial training within the first year, and caregivers must complete initial training prior to assisting any recipient with medication administration.

ADSD does not provide training for medication deficiencies as this is within the jurisdiction of HCQC.

Providers are required to report all medication errors via a SOR. All SOR's are tracked by the ADSD QA and DHCFP LTSS for analysis and reporting. All medication errors are sent to HCQC via an Alert memorandum. All entities work together to ensure remediation efforts are taken when necessary.
This may include a referral to the ADSD APS or Long Term Care Ombudsman to ensure health, safety and welfare of the Waiver recipient.
All enrolled Waiver Providers are required to self-report medication errors.

HCQC conducts investigations, imposes monetary fines, requires corrective action plans for substantiated reports and may suspend or revoke licensure as appropriate.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of recipients serious occurrence report of abuse, neglect, exploitation, isolation, or abandonment with appropriate action taken. N: Number of serious occurrences report of abuse, neglect, exploitation, isolation, or abandonment with appropriate action taken. D: Total number of serious occurrences reported.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: Case Management Agencies	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of unexplained death, as reported through the Serious Occurrence Report process that receives appropriate follow-up. N: Total number of unexplained deaths, as reported through the SOR process that received proper follow up. Denominator: Total number of unexplained deaths reported through the SOR process.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Serious Occurrence Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of recipients who received information about how to report Abuse/Neglect/Exploitation initially and annually thereafter. Numerator: Total number of recipients who receive information on how to report A/N/E. Denominator: Total number or recipients reviewed.

Data Source (Select one):

Other
If 'Other' is selected, specify:
Recipient rights form.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: Case Managment Provider	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of recipient serious occurrence reports that include appropriate follow up. N: Number of serious occurrence reports that received appropriate follow up. D: Number of serious occurrence reports requiring follow up.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Serious Occurrence Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative**

		Sample Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of unauthorized incidents of restraint and coercion, as reported through the Serious Occurrence Report and received appropriate follow-up. Numerator: Total number or unauthorized incidents of restraint and coercion and received appropriate follow-up. Denominator: Total number of unauthorized incidents of restraint and coercion reported through the SOR process.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Serious Occurrence Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: Case Managment provider	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of recipients who received information about how to report unauthorized occurrences of restraint and coercion initially and annually thereafter. Numerator: Total number of recipients who receive information on how to report unauthorized occurrences of restraint and coercion. Denominator: Total number of recipients reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Recipient rights form.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: Case Managment Provider	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of recipients who receive information initially and annually regarding preventative health care. N: Total number of recipients who receive information initially and annually regarding preventative health care. D: Total number of recipients.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Recipient rights form

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☒ **Other** Specify: Case Manager Provider	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Per NRS 200.5093, policy that every employee adheres to reporting instances of abuse, neglect, exploitation, isolation, or abandonment to the APS unit.

Case Managers seek to prevent instances of abuse, neglect, exploitation, isolation, or abandonment and ensure the health, welfare and safety via monthly contacts with recipients.

Case Management providers are responsible to review a 95/5 Confidence Interval sample size of ongoing case files which identify person centered contacts, concerns, needs, follow-up action, and waiver satisfaction. These reviews are captured on a Case File Review format and submitted to DHCFP QA as requested. DHCFP QA reports this data at the quarterly QI meeting for review and recommendations.

Public Case Management SOR Database - The SOR Database is used by the ADSD Case Managers to receive reports, track outcomes and provide data to the DHCFP LTSS. Providers, the public and ADSD can access this database on the DHCFP public website as well as the DHCFP Fiscal Agent website. When a SOR is completed and submitted through the portal, it will alert the ADSD Case Manager. The Case Manager will review the information, contact the recipient or reporting party and provide necessary follow-up to ensure the health, safety, and welfare of the recipient. Once the SOR is considered closed, the database is updated, and it is reviewed by the Case Managers supervisor for accuracy. If the Supervisor determines additional follow-up is required, they will communicate this to the Case Manager. If the Supervisor determines the outcome was appropriate, it will be considered closed. The ADSD QA unit will conduct a 95/5 Confidence Interval sample of closed SOR's to determine appropriates, and report this data to the DHCFP LTSS for analysis and reporting.

Private Case Management SOR database is not available through public facing DHCFP website; therefore, any incident report for a recipient receiving PCM must be submitted in paper form to DHCFP LTSS inbox at hcbs@dhcfp.nv.gov. Paper form will be re-routed to PCM who will enter the SOR in their database and perform the necessary follow-up. PCM will provide a report to DHCFP on a quarterly basis or upon request.

Safeguards regarding unauthorized restraints and seclusion - The Case Management providers, DHCFP QA and the ADSD QA is responsible for detecting the unauthorized use of seclusion. This is accomplished through ongoing person-centered contacts with waiver recipients, annual PES, and scheduled residential setting visits and reviews. The recipient is provided the phone number of their Case Manager, and their Case Managers supervisor, and has been advised to call if there are any problems or concerns. The Case Manager will assess any reported incidents of seclusion, and call the appropriate authorities, if applicable. The recipient is provided the contact information for APS and local law enforcement when they sign and receive a copy of the Recipients Rights form.

RFGs are licensed and monitored by HCQC for unauthorized restraints or seclusion. If a Waiver recipient is identified to have received, or is suspected of receiving unauthorized restraints or seclusion, this is reported to the Case Management provider for appropriate placement into another setting of their choice.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Case Managers provide a copy of the HCBS Recipient Rights form to all Waiver recipients at the initial home visit and annual home visits. The Recipient Rights form includes the following:

- the right to not to be physically, sexually, or otherwise abused, not to be neglected, not to be exploited, and not to be isolated and freedom from coercion.
- contact information for APS and law enforcement regarding suspected abuse, neglect, or exploitation.
- the name and contact number for their Case Manager and their Case Managers supervisor if issues arise. Case Managers are responsible for identifying and addressing issues/concerns, and providing appropriate referral and contact information for other resources as applicable.

Case Managers refer and provide consult to ADSD APS incidents of suspected abuse, neglect, exploitation, isolation, or abandonment. ADSD APS provide training as requested regarding mandated reporting requirements as well as areas of abuse, neglect and exploitation. If trends are identified, they will be discussed during the quarterly QI meeting for corrective action strategies.

Education is provided to Waiver providers regarding the SOR requirements. Training includes required timeframes, reportable areas of concern, follow-up and communication requirements and the acceptable reporting methods. During the annual provider review, ADSD QA verifies that serious occurrences are being completed, followed up on, and kept on file as appropriate.. If a provider is out of compliance, they are issued a Corrective Action Plan and additional training may be provided as applicable.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of health and welfare that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under Section 1915(c) of the Social Security Act and 42 CFR § 441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality improvement is 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.

CMS recognizes that a state's waiver quality improvement strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a quality improvement strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the quality improvement strategy.

Quality Improvement Strategy: Minimum Components

The quality improvement strategy (QIS) that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the QIS spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the QIS. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

DHCFP and ADSD are working together to continuously assess quality improvement to ensure CMS requirements for assurances and sub-assurances are being met:

a) DHCFP QA facilitates monthly Comprehensive Quality Improvement (QI) meetings which include: performance measures that scored below 86% are assigned to one of the two priority grids, discussion on how to remediate and mitigate those deficiencies using CMS guidelines:
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?), address deficiencies to and develop trainings for waiver case managers and providers.

b) Consistency meetings are also being held quarterly between ADSD and DHCFP QA and LTSS staff to ensure that ADSD review tools are aligned with waiver Performance Measures (PM) as stated in the approved waiver. Additionally, consistency meetings serve as a communication tool to assist in educating/updating both ADSD and DHCFP staff regarding waiver requirements and any changes made to PMs (if any) and assure consistency in quality assurance reviews across the two (2) state agencies.
c) Communication Meeting, scheduled on as needed basis. This is a team effort between two agencies (DHCFP and ADSD) when there is a need to update Medicaid Waiver policies, Waiver renewal and amendments.
d) Training - DHCFP in collaboration with ADSD will be conducting training/education to case managers annually with emphasis on the importance of CMS requirements regarding waiver compliance and provide updates pertaining to DHCFP's policies.

Health and Welfare:
The State has a stringent policy regarding neglect/abuse/exploitation/death. All reported neglect/abuse/exploitation or death are also reported to law enforcement, Adult Protective Services (APS), or NV licensing agency and families (if applicable). All CMs and providers are all mandated reporters.

ADSD utilizes and owner of SOR (Serious Occurrence Report) Harmony Database which captures all reported cases including A/N/E, abandonment and isolation, medication management error, case managers' (CM) follow-ups and supervisors and ADSD QA review of CMs to ensure appropriate follow-up was made.
In March 2023, DHCFP will be enrolling a Private Case Management agency, which will have their own tracking database for all reported cases and follow-ups mentioned above.

All reported incidents that have been followed-up and remediated by public and private case management will be consolidated and submitted to DHCFP for review and submission to CMS via 372 report.

DHCFP will start tracking A/N/E and unexpected death in real time. When there's a report of A/N/E and unexpected death, CM will send an "alert memo" to DHCFP LTSS, which will be logged in a spreadsheet. Quarterly, DHCFP will send the report to APS for any updates/action taken pertaining to the case(s) being investigated. Findings and outcomes, action steps will be documented on the spreadsheet which will be submitted to CMS via 372 reports as well as the evidentiary report.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The Division of Health Care Financing and Policy (DHCFP) is the administrator of Home and Community Based Services Waiver for Persons with Physical Disabilities (PD). DHCFP Long Term Services and Supports (LTSS) Unit is responsible for the submission of waiver renewal, amendments and 372 reports to CMS as well as administering and updating waiver policies. DHCFP Quality Assurance (QA) Unit conducts annual reviews of case files, financial, and recipient survey called Participant Experience Survey (PES).

The Aging and Disability Services Division (ADSD) is the operating agency, which also has a QA unit and responsible for conducting waiver provider reviews annually as well as conducting PES in collaboration with DHCFP QA unit.

Consolidation Review and Reporting of Waiver Operations of Waivers (Frail Elderly (FE) and Physically Disabled (PD)), which was approved by CMS:

The Persons with Physical Disabilities & Frail Elderly waivers currently meet the conditions outlined by CMS to consolidate reviews and reporting across multiple waivers.
1. Design of waivers is the same or similar;
2. This sameness or similarity is determined by comparing waivers on the approved waiver applications appendices; and
3. The quality management approach is the same or very similar across waivers.
The report includes a cumulative total percent of compliance for all performance measures as well as a breakdown by regional office and/or waiver upon request by the operating agency or State Administrative staff.

Methodology:
DHCFP QA will run a query in Decision Support System (DSS) Advantage Suite to determine the cumulative number of the statewide population of recipients in receipt of services under both waivers during the preceding 12 month period. This consolidated list of recipients will be used to determine the stratified sample size for the annual review.

Each year, a random sample of the consolidated list will be selected producing a probability of 95% confidence level with +/- 5 confidence interval determining the statewide total of recipient files to be reviewed by DHCFP QA and Case Management Agencies. Another sample producing a 95% +/-5 confidence level will be generated using the same consolidated list to determine the required number of recipient files and Participant Experience Survey will be evaluated throughout the year by DHCFP and ADSD QA. The consolidated review started in 2015 and yearly thereafter; however, the reporting covers 2 years of annual review to ensure both FE and PD waiver years are captured.

DHCFP and ADSD developed a comprehensive stratified provider review process. This stratified review will cover all provider types that provide services to all waiver recipients as well as State Plan services. The provider reviews will be completed by DHCFP and ADSD QA staff. With regards to training requirements, criminal background check and TB testing, the state licensing agency, Bureau of Health Care Quality and Compliance (HCQC) is the responsible party to conduct the audit to ensure that providers are in compliance with the regulations.
The annual consolidated report will cover July 1 to June 30 of each year. The consolidated evidence report will be submitted in accordance with each waiver's reporting schedule.

The state strives to meet the waiver Assurances and Sub-assurances through the performance measures with the score of 95% or higher. Additionally, the purpose of system monitoring and improvement is to ensure that community services are delivered to recipients safely and in the most cost efficient manner.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

Quality management is a system that changes and improves over time. The process of data analysis, setting goals, monitoring outcomes and identifying problem areas leads to continual adjustment of the quality management strategy.

The Quality Management Meetings are used to evaluate the quality management strategy on an ongoing basis to evaluate the effectiveness, efficiency and appropriateness of the quality management system and update the system on an as needed basis. Evidentiary reports, annual review findings, and Plans of Improvement are utilized to evaluate, set priorities, and updates these activities on an as needed basis.

The Quality Improvement Strategy is reviewed and updated annually, based on information gathered from all of the activities completed throughout the year, and the annual waiver review. If there were no serious concerns, the Strategy may not change. If additional items need to be monitored, DHCFP and ADSD will modify the Strategy to include this additional monitoring.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- (●) **No**
- ( ) **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ( ) **HCBS CAHPS Survey :**
- ( ) **NCI Survey :**
- ( ) **NCI AD Survey :**
- ( ) **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

The NV Medicaid Management Information System (MMIS) went through modernization and went live on February 2, 2019 now called Interchange (IC). MMIS increases efficiency in enrolling Medicaid providers, authorizing services, faster processing of providers claims, and has a built-in Medically Unlikely Edit (MUE). MMIS claims processing system identifies the provider, authorized services, and units of service for each recipient. The State's MMIS is linked to DWSS/NOMADS eligibility system. MMIS has a built-in edit which maps the claims to eligible waiver recipient, active waiver provider and prior authorization. If MMIS detects errors, claims are automatically denied. DHCFP LTSS unit works closely with Medicaid waiver providers and DHCFP Business Process Management Unit (BPMU) in resolving any unpaid or denied claims. Further, the MMIS maintains records of incurred and paid claims, both the recipient and the provider files and provides data for the CMS 64 and CMS 372 reports. Medicaid waiver provider agencies are not required to secure an independent review of financial statements. All claims are submitted electronically through Interchange. In addition to the Interchange audit, DHCFP QA staff completes an annual financial 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, waiver requirements, and waiver policy. The financial review utilizes the statewide random sample of recipients selected for program review. A list of claims paid is produced from the Decision Support System (DSS) for each sample case for all waiver services for one chosen month.

All waiver claims for that sample month for that recipient are examined, in conjunction with the PCSP and daily record documentation. Results of financial reviews are reported to CMS through annual 372 reporting. If the outcome of the financial review results in an identified error including a possible overpayment, it is referred to DHCFP Surveillance and Utilization Review (SURs) Unit for further investigation and possible recoupment. Analysis Under the provisions of the Single Audit Act - The NV Legislative Counsel Bureau Audit Division is responsible for contracting with an independent public accounting firm to conduct a statewide audit of the state's financial statements.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:
The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.

i. Sub-Assurances:

a. Sub-assurance: The state provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

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. N: Number of recipients claims that are coded and paid correctly in accordance with the service plan, daily record, and prior authorization. D: Number of claims reviewed.

Data Source *(Select one):*
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% confidence level and +/- 10% margin of error*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The State provides evidence that rates remain consistent with the approved rate methodology through the five year waiver cycle. Number and percent of provider payment rates which are consistent with the rate methodology in the approved waiver. N: Total number of payment rates which are consistent with the rate methodology in the approved waiver. D: Total number provider payment rates reviewed

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Interchange verification that rates paid to providers are in line with approved rate methodology.

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence*

		Interval = *95% confidence level and +/- 5% margin of error*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the*

state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The DHCFP QA reviews all financial claims for the 95/10 sample which is derived from the 95/5 Stratified sample pull of active participants for the Waiver year. This includes all waiver services received during that selected month.

The 95/10 selection of casefile reviews completed by the DHCFP QA unit are then reviewed for a random month selection of review of all paid claims. If errors are discovered during the financial month's review, the information is forwarded to DHCFP SUR unit, wherein they conduct an independent and expanded review to see if it is an education issue or a more systemic and/or possible fraud issue.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.*

All Medicaid Providers are responsible to validate billing and ensure integrity of all claims submitted to the DHCFP Fiscal Agent. Factors reviewed include recipients, dates of service, authorization, procedure code, Medicaid Provider number, eligibility effective date, modifier (if applicable), and rate. The review is based on claims history reports generated from Interchange.

In addition to internal monitoring procedures conducted by Medicaid Providers, DHCFP QA completes an annual review to ensure financial integrity. If deficiencies are identified during the financial review, a referral is made to the SURs Unit and/or MFCU. These units investigate referrals and will investigate fraud waste and abuse and take necessary action. The SURs Unit will issue education to providers regarding policies for proper billing and rules and regulations for Medicaid providers. In addition, DHCFP's Fiscal Agent provides training to all new Medicaid Providers on billing procedures and to active Medicaid providers upon request how to submit claims electronically s. If provider training efforts fail, DHCFP may suspend the provider from accepting new Medicaid recipients and request a corrective action plan.

If there are errors found within MMIS during the annual review, there is a mechanism in place to correct these issues. The errors that have been noted in the past include incorrect rates, payments edits that are not functioning, or payment edits that need to be included so claims pay appropriately. When these types of errors are noted, a form called a Production Discrepancy Report (PDR) is completed which identifies the nature of the problem. The PDR is submitted to the Fiscal Agent for a Scope of Work which outlines the amount of time and cost of fix. DHCFP Business Process Management Unit (BPMU) staff approves all work related to MMIS.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
	☐ ***Other*** *Specify:*

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ ***No***

○ ***Yes***

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

The Division of Health Care Financing and Policy (DHCFP) determines all rates. Documentation of the assumptions, inputs, rate development methodology, and fee-schedule payment rates are maintained by DHCFP. The rate determinations are done in house with programmatic staff, stakeholders as well as at the direction of the Nevada Legislature. Oversight of the rate determination process is done at the Administrative level of DHCFP. Waiver reimbursement rates are available to all waiver participants at DHCFP's website, listed by provider type at: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules.

Effective January 1, 2018, Nevada Revised Statute (NRS) 422.2704 requires the DHCFP to review the rates of all Medicaid providers every four years. This review is conducted through a survey that compares Medicaid providers' actual costs of delivering services to the reimbursement rates. If DHCFP finds that the reimbursement rates do not accurately reflect the actual costs, a recommendation is submitted to the Director of the Department of Health and Human Services (DHHS) for consideration in future budget requests.

Direct Care Waiver Services include:
S5130 - Homemaker
S5135 - Adult Companion Services
S5150 - Respite (15 minutes)
S5151 - Respite (per diem)
S5120 - Chore Services
S5100 - Adult Day Care (15 minutes)
S5102 - Adult Day Care (per diem)

Homemaker, Respite and Adult Companion Rate Methodology:
During the 2023 Session of the Nevada Legislature, the rates for Homemaker, Respite, and Adult Companion received a rate increase. The rates are tied to a recommendation from the Home Care Employment Standards Board. The recommendation to the Director can be found here:
https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/HCESB/Recommendation%20to%20Director%20Rates%20and%2

Chore and Adult Day Care Services Rate Methodology:
As a requirement of the last Frail Elderly (FE) Waiver Renewal, DHCFP initiated a comprehensive review of waiver service rates and documentation of rate methodologies in October of 2019, completing it in February 2020. This review was required due to lack of detailed historical data regarding waiver rates and methodologies.

The 2019 rate review included an electronic wage and benefit survey for waiver service providers, with the option for providers to submit a paper-based response. Providers were given four months to respond before the survey was closed and the results were analyzed. The respondent pool represented 17% of FE waiver providers who delivered services to 21% of FE waiver recipients. The data obtained was sufficient to provide reliable insights into wages, full- and part-time status of direct caregivers, average travel and documentation time, and provided benefits. Additionally, an interstate comparison was made with adjoining states and others with similar waiver services, covering a total of six states.

The rate model was developed using an hourly base wage, which was adjusted to reflect service definitions, provider requirements, operational service delivery, and administrative considerations.

The following elements are used to determine the rates:
1. Wage Information: Data from provider surveys was compared to wages for similar services in other states and to wages identified by Medicaid staff for comparable State Plan Services.

2. Employee-Related Expenses (ERE): A percentage of 27% was applied, based on input from Medicaid staff and approved State Plan direct care service methodologies. This percentage includes paid vacation, sick leave, holiday pay, health insurance, life insurance, disability, workers' compensation, and legally required payroll taxes.

3. Productivity Adjustment Factor: This accounts for non-billable time, including time spent on travel and required documentation. Productivity assumptions are based on input from waiver policy staff and provider survey. The assumption is that in an 8-hour day, staff will spend approximately 30 minutes on documentation and 48 minutes traveling between recipients. This non-billable time is subtracted from the 8 hours, leaving 6.7 hours of "billable" time. The productivity factor is calculated by dividing total hours by billable hours, which is then applied to increase the ERE-

adjusted hourly wage.

4. Administrative Overhead: A 10% administrative overhead is applied, based on Nevada Medicaid's State Plan, covering non-direct care activities such as insurance, administrative staff, operations, management, and office supplies. This does not exceed the percentage allowable by state law.

The following steps are used to determine the rates:
1. Start with the hourly base wage for each service.
2. Increase the hourly amount by 27% for ERE.
3. Apply the productivity factor to the adjusted hourly wage.
4. Add 10% administrative overhead to the adjusted hourly rate.
5. The total hourly rate is the sum of the adjusted hourly rate and administrative overhead.
6. The final total hourly rate is scaled to the appropriate unit based on the unit of service.

Non-Direct Care Waiver Services include:
S5160 - Personal Emergency Response System (PERS) Install
S5161 - PERS Monthly
S5170 - Home Delivered Meals

Non-Direct Care Rate Methodology:
PERS Install and PERS Monthly - The rate calculation for PERS is based on the actual cost billed to the Aging and Disability Services Division (ADSD) by the service provider in 2002. The rates for the one-time installation charge and the subsequent monthly fee were initially set in 2002 and have been reviewed periodically, with the most recent review conducted in 2022. These rates were found to be consistent with the efficiency, economy, and quality of services, and were comparable to those in other states offering similar services.

Home Delivered Meals Rate Methodology:
As part of the American Rescue Plan Act (ARPA), the division contracted with Myers and Stauffer to conduct rate study of Nevada Medicaid Home and Community Based Services (HCBS), which began in January 2023 and completed in March 2024. As a result of the rate study, Home Delivered Meal rate was increased. The rate study assessed state and national environmental scan of labor costs per meal and program related expenses to determine the recommended wage per meal.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

The 21st Century Cures Act, requires the use of an EVV system to document services that are provided for all personal care services under a Medicaid State plan or waiver programs. This mandate requires provider agencies to use an EVV system to record service delivery visit information. Nevada Medicaid utilizes the open system model, procuring a vendor but also allows agencies to utilize their own if it meets the 21st Century Cures Act requirements for documentation.

All service information must be recorded in an electronic system that interfaces with either a telephone or an electronic device that generates a timestamp. The provider agency must verify the EVV record, including any visit maintenance, prior to submitting a claim associated with the EVV record. All claims must be supported by an EVV entry into an EVV system prior to claim submission. Agencies must ensure each personal care attendant has a unique identifier (National Provider Identification – NPI) associated with their worker profile in the EVV system.
State Option:
a. The EVV system electronically captures:
1. The type of service performed, based on procedure code;
2. The individual receiving the service;
3. The date of the service;
4. The location where service is provided;
5. The individual providing the service; 6. The time the service begins and ends.
b. The EVV system must utilize one or more of the following:
1. The agency/personal care attendant's smartphone;
2. The agency/personal care attendant's tablet;
3. The recipient's landline telephone;
4. The recipient's cellular phone (for Interactive Voice Response (IVR) purposes only);
5. Other GPS-based device as approved by the DHCFP.

DATA AGGREGATOR OPTION:
All Personal Care and Waiver Provider Agencies that utilize a different EVV system (as approved by the DHCFP) must comply with all documentation requirements and must utilize the data aggregator to report encounter or claim data. Appropriate form must be approved by the DHCFP before use of system to ensure all data requirements are being collected to meet the 21st Century Cures Act. At a minimum, data uploads must be completed monthly into data aggregator.

Currently, Nevada Medicaid Waiver providers providing direct waiver services such as Homemaking, Respite, Adult Companion and Chore are required to use the EVV system.

All other Medicaid Waiver providers providing non-direct waiver services such as Home Delivered Meals, Augmented Personal Care Services (APC), and PERS are not required to use EVV system, but must submit all claims electronically through the Medicaid Management Information System (MMIS) Interchange.
The MMIS adjudicates claims by:
1. Verifying recipient eligibility.
2. Verifying eligibility of waiver service codes.
3. Verification of prior authorization.
4. Verification that providers have an active status in MMIS.
MMIS has a series of edits which verifies name, Medicaid number, prior authorization, and the number of units of service authorized. If the claim fails just one of these areas, the claim will deny. The provider must resubmit claims with the correct information. There is an edit in the system which verifies
Providers do not receive reimbursement over what is authorized. Provider claims are stored in a data warehouse and can be accessed through reports.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- ◉ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services***

and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

a) The Medicaid Management Information System (MMIS) assures that all claims for payment are made when the recipient was eligible for the Medicaid Waiver on the date of service and that there was an active PA for the service in question.

The recipient and provider subsystems within MMIS record various benefit plans, reflects enrollee eligibility data, while also supplying demographic and other data used to adjudicate payment requests.

The reference subsystem and the claims processing subsystem identify the covered services for the benefit plan as well as the associated edits and rates of the service.

b) The Case Management provider maintains a corresponding record for each recipient documenting the recipient's waiver eligibility and services provided. The record includes recipient demographics, assessments, PCSPs, LOC screenings, ongoing LOC, and documentation of waiver service authorizations. A 95/10 Stratified sample of financial records are reviewed during the DHCFP annual review to ensure accurate payment.

c) Waiver providers keep a record or signed timesheet to verify that services were provided in accordance with the PCSP.

When a recipient's eligibility for the waiver is terminated, the benefit plan is updated to indicate the date of termination. As claims are processed for payment, an edit is performed to ensure the date of service on the claim is within the eligibility dates identified in the benefit plan and the services billed are included in the benefit plan.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

◉ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***

○ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

○ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*

◉ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

ADSD staff provides case management as a waiver service. Case management is broken up into Administrative and Direct Service. (Reference I-2.b for a breakdown of Administrative and Direct Services). The type of case management provided is tracked in an electronic time sheet. Only Direct Service case management is billed as a waiver service.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- ○ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ◉ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.***
- ○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- ◉ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ○ ***This waiver is a part of a concurrent section 1915(b)/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***This waiver is a part of a concurrent section 1115/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may

voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid Agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☒ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

During the 76th Legislative Session, SB 485 was passed which amended the counties responsibility to pay the State's Share of expenditures for indigents who are institutionalized with income at 156% to 300% of the Federal Benefit Rate (FBR). The bill amended this population lowering the FBR to an amount prescribed annually by the Director and included the waiver population within the same income limits. The FBR was lowered to 142%.

The counties reimburse these expenditures through property taxes collected. This is not a CPE mechanism as the counties are not providing the services to these recipients. This is a reimbursement of expenditures in which the counties are responsible to pay through property taxes collected. The expenditures include waiver and state plan services provided by private community providers.

DHCFP obtains those funds from the counties by invoicing each county, monthly, based on projected costs for the recipients the county is responsible for. A reconciliation is completed each quarter.

DHCFP updated the contracts of all 17 Nevada counties in 2013 to state "payments made by the County shall be derived from general county tax revenues or other general revenues of the County".

The State provided CMS a separate document titled Waiver Services other than Case Management: M200 County Match and SB 485 Adjustment. This document lays out how counties are invoiced for their estimated portion of Medicaid services.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

○ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

◉ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☒ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

SB 485 passed during the 2011 Legislative Session imposed responsibility upon the counties to reimburse the non-federal share of expenditures for waiver recipients whose income is at 142% to 300% of the FBR. These amounts are capped at the amount approved through the biennial budget process.

The State provided CMS a separate document titled Waiver Services other than Case Management: M200 County Match and SB 485 Adjustment. This document lays out how counties are invoiced for their estimated portion of Medicaid services.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Medicaid does not pay the cost of room and board furnished to an individual under the waiver. For all services room and board costs are excluded from payment. Individual resources such as SSI, Social Security, Pensions or Savings cover room and board. Rates are based on service delivery, not room and board.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing *(1 of 5)*

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

☐ ***Nominal deductible***

☐ ***Coinsurance***

☐ ***Co-Payment***

☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***

○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	16341.33	3966.00	20307.33	66060.00	16533.00	82593.00	62285.67
2	16197.85	3954.00	20151.85	67579.00	17740.00	85319.00	65167.15
3	16097.39	3942.00	20039.39	69134.00	19035.00	88169.00	68129.61
4	16030.82	3930.00	19960.82	70724.00	20424.00	91148.00	71187.18
5	15966.45	3919.00	19885.45	72350.00	21915.00	94265.00	74379.55

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates *(1 of 9)*

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	4108	4108
Year 2	4419	4419
Year 3	4663	4663
Year 4	4875	4875
Year 5	5057	5057

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates *(2 of 9)*

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The average length of stay is based on the total number of days of waiver coverage of all recipients enrolled in the Waiver for the Frail Elderly divided by the unduplicated number of recipients in the waiver. Actual average length of stay was calculated based on the 372 data for the period of July 01, 2019 - June 30, 2023. The average length of stay is 306.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Unduplicated Participants Projection Calculation:
Entry to the program is modeled using a seasonally adjusted ARIMA (auto-regressive integrated moving average) model trained on 396,031 individual-month observations from December 2009 to December 2024. For the projection period, this model predicts an average of 104 new cases a month with an annual growth in caseload averaging 5.5% since 2017 on the back of a gradual increase in entry rate coupled with a slow decline in the hazard rate (monthly individual probability of disenrollment). Growth in the senior (65+) population of 1% is associated with a 1.68% increase in the FE Waiver caseload. Though growth in this population segment has slowed in the past two years, it is still expected to average 2.5% per year through the end of the decade, so it is clear that this is a major driver of FE caseload trends, using 372 WY2023 unduplicated participants count as the baseline.

Users per waiver service:

Using the 5 year 372 reports (WY 2019-2023): 1) the estimated percentage of users was calculated by dividing the number of participants for each waiver service to the total number of waiver participants for each waiver year; 2) the percentage of users was averaged out across the 5 years; 3) the average percentage of projected unduplicated count is used for the estimated number of users per waiver service per year.

Units per user:

Using the 5 year 372 reports (WY 2019-2023), the estimated units per user was calculated by dividing the service count per participant for each waiver service to the number of waiver participants for each waiver service; then averaged out across 5 years.

Average cost per unit:

Cost per unit is based on the current service rates.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Although, other state plan health care services are included in the calculation of Factor D', historical data shows a downward slope in growth. Based on the actual expenditures from 372 reports for WYs 2014-2018, the average growth rate is -0.3%, which was used to determine the Factor D' for this renewal WY1, using WY 2018 as the baseline.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The nursing facility costs are estimated based on the statewide actual average growth rate of the previous 5 years' actual cost obtained from 372 reports WY 2014-2018. The State decided to use the actual average growth rate of actual cost obtained from 372 reports for WYs 2014-2018, using the WY 2018 as the baseline.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Non-institutional state plan costs are estimated based on the statewide actual average growth rate of the previous 5 years' actual cost obtained from 372 reports WYs 2014-2018. The State decided to use the actual average growth rate of the actual cost obtained from 372 reports for WYs 2014-2018, using the WY 2018 as the baseline.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Case Management	
Homemaker	
Respite	
Adult Companion	
Adult Day Care	
Augmented Personal Care (APC)	
Chore	
Home Delivered Meals	
Personal Emergency Response System (PERS)	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Case Management Total:						***1800413.58***
Case Management (Private)	*1/4 hour*	*1000*	*14.00*	*15.84*	***221760.00***	
Case Management (Public)	*1/4 hour*	*2919*	*14.00*	*38.63*	***1578653.58***	
Homemaker Total:						***2392500.00***
Homemaker	*1/4 hour*	*880*	*435.00*	*6.25*	***2392500.00***	

GRAND TOTAL:	***67130193.02***
Total Estimated Unduplicated Participants:	***4108***
Factor D (Divide total by number of participants):	***16341.33***
Average Length of Stay on the Waiver:	*288*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:						**1400700.00**
Respite per diem	per diem	4	1.00	150.00	**600.00**	
Respite per unit	1/4 hour	312	718.00	6.25	**1400100.00**	
Adult Companion Total:						**256500.00**
Adult Companion	1/4 hour	95	432.00	6.25	**256500.00**	
Adult Day Care Total:						**479043.25**
Adult Day Care per diem	per diem	104	109.00	42.00	**476112.00**	
Adult Day Care per unit (1/4 hour)	1/4 hour	5	335.00	1.75	**2931.25**	
Augmented Personal Care (APC) Total:						**51497235.94**
APC Level of Service 1 (U1)	per diem	224	196.00	68.75	**3018400.00**	
APC Level of Service 2 (U2)	per diem	524	187.00	103.13	**10105502.44**	
APC Level of Service 3 (U3)	per diem	547	185.00	137.50	**13914312.50**	
APC Level of Service 4 (U4)	per diem	411	478.00	124.50	**24459021.00**	
Chore Total:						**3806.25**
Chore	1/4 hour	29	35.00	3.75	**3806.25**	
Home Delivered Meals Total:						**8530494.00**
Home Delivered Meals	Per Meal	2758	300.00	10.31	**8530494.00**	
Personal Emergency Response System (PERS) Total:						**769500.00**
PERS (monthly)	per month	2079	9.00	40.00	**748440.00**	
PERS Installation	1 system	468	1.00	45.00	**21060.00**	

GRAND TOTAL:	**67130193.02**
Total Estimated Unduplicated Participants:	**4108**
Factor D (Divide total by number of participants):	**16341.33**
Average Length of Stay on the Waiver:	288

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to*

automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						1961037.12
Case Management (Private)	1/4 hour	1000	14.00	15.84	221760.00	
Case Management (Public)	1/4 hour	3216	14.00	38.63	1739277.12	
Homemaker Total:						2571937.50
Homemaker	1/4 hour	946	435.00	6.25	2571937.50	
Respite Total:						1503912.50
Respite per diem	per diem	4	1.00	150.00	600.00	
Respite per unit	1/4 hour	335	718.00	6.25	1503312.50	
Adult Companion Total:						278100.00
Adult Companion	1/4 hour.	103	432.00	6.25	278100.00	
Adult Day Care Total:						515667.25
Adult Day Care per diem	per diem	112	109.00	42.00	512736.00	
Adult Day Care per unit (1/4 hour)	1/4 hour	5	335.00	1.75	2931.25	
Augmented Personal Care (APC) Total:						55385501.84
APC Level of Service 1 (U1)	per diem	241	196.00	68.75	3247475.00	
APC Level of Service 2 (U2)	per diem	564	187.00	103.13	10876914.84	
APC Level of Service 3 (U3)	per diem	588	185.00	137.50	14957250.00	
APC Level of Service 4 (U4)	per diem	442	478.00	124.50	26303862.00	
Chore Total:						4068.75
Chore	1/4 hour	31	35.00	3.75	4068.75	
Home Delivered Meals Total:						8530494.00
Home Delivered Meals	Per Meal	2758	300.00	10.31	8530494.00	

GRAND TOTAL:	71578313.96
Total Estimated Unduplicated Participants:	4419
Factor D (Divide total by number of participants):	16197.85
Average Length of Stay on the Waiver:	288

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response System (PERS) Total:						**827595.00**
PERS (monthly)	per month	2236	9.00	40.00	**804960.00**	
PERS Installation	1 system	503	1.00	45.00	**22635.00**	
				GRAND TOTAL:		**71578313.96**
				Total Estimated Unduplicated Participants:		**4419**
				Factor D (Divide total by number of participants):		**16197.85**
				Average Length of Stay on the Waiver:		288

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**2087048.18**
Case Management (Private)	1/4 hour	1000	14.00	15.84	**221760.00**	
Case Management (Public)	1/4 hour	3449	14.00	38.63	**1865288.18**	
Homemaker Total:						**2716031.25**
Homemaker	1/4 hour	999	435.00	6.25	**2716031.25**	
Respite Total:						**1589325.00**
Respite per diem	1/4 hour	5	1.00	150.00	**750.00**	
Respite per unit	per diem	354	718.00	6.25	**1588575.00**	
Adult Companion Total:						**291600.00**
Adult Companion	1/4 hour	108	432.00	6.25	**291600.00**	
Adult Day Care Total:						**543721.50**
Adult Day Care per diem	per diem	118	109.00	42.00	**540204.00**	
				GRAND TOTAL:		**75062137.88**
				Total Estimated Unduplicated Participants:		**4663**
				Factor D (Divide total by number of participants):		**16097.39**
				Average Length of Stay on the Waiver:		288

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care per unit (1/4 hour)	1/4 hour	6	335.00	1.75	3517.50	
Augmented Personal Care (APC) Total:						58426222.95
APC Level of Service 1 (U1)	per diem	254	196.00	68.75	3422650.00	
APC Level of Service 2 (U2)	per diem	595	187.00	103.13	11474759.45	
APC Level of Service 3 (U3)	per diem	621	185.00	137.50	15796687.50	
APC Level of Service 4 (U4)	per diem	466	478.00	124.50	27732126.00	
Chore Total:						4200.00
Chore	1/4 hour	32	35.00	3.75	4200.00	
Home Delivered Meals Total:						8530494.00
Home Delivered Meals	Per Meal	2758	300.00	10.31	8530494.00	
Personal Emergency Response System (PERS) Total:						873495.00
PERS (monthly)	per month	2360	9.00	40.00	849600.00	
PERS Installation	1 system	531	1.00	45.00	23895.00	

GRAND TOTAL:	75062137.88
Total Estimated Unduplicated Participants:	4663
Factor D (Divide total by number of participants):	16097.39
Average Length of Stay on the Waiver:	288

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						2196293.82
Case Management					221760.00	

GRAND TOTAL:	78150253.14
Total Estimated Unduplicated Participants:	4875
Factor D (Divide total by number of participants):	16030.82
Average Length of Stay on the Waiver:	288

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
(Private)	1/4 hour	1000	14.00	15.84		
Case Management (Public)	1/4 hour	3651	14.00	38.63	1974533.82	
Homemaker Total:						2838375.00
Homemaker	1/4 hour	1044	435.00	6.25	2838375.00	
Respite Total:						1661125.00
Respite per diem	per diem	5	1.00	150.00	750.00	
Respite per unit	1/4 hour	370	718.00	6.25	1660375.00	
Adult Companion Total:						305100.00
Adult Companion	1/4 hour	113	432.00	6.25	305100.00	
Adult Day Care Total:						571189.50
Adult Day Care per diem	per diem	124	109.00	42.00	567672.00	
Adult Day Care per unit (1/4 hour)	1/4 hour	6	335.00	1.75	3517.50	
Augmented Personal Care (APC) Total:						61130118.32
APC Level of Service 1 (U1)	per diem	266	196.00	68.75	3584350.00	
APC Level of Service 2 (U2)	per diem	622	187.00	103.13	11995462.82	
APC Level of Service 3 (U3)	per diem	649	185.00	137.50	16508937.50	
APC Level of Service 4 (U4)	per diem	488	478.00	124.50	29041368.00	
Chore Total:						4462.50
Chore	1/4 hour	34	35.00	3.75	4462.50	
Home Delivered Meals Total:						8530494.00
Home Delivered Meals	Per Meal	2758	300.00	10.31	8530494.00	
Personal Emergency Response System (PERS) Total:						913095.00
PERS (monthly)	per month	2467	9.00	40.00	888120.00	
PERS Installation	1 system	555	1.00	45.00	24975.00	

GRAND TOTAL:	78150253.14
Total Estimated Unduplicated Participants:	4875
Factor D (Divide total by number of participants):	16030.82
Average Length of Stay on the Waiver:	288

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Case Management Total:						***2290396.50***
Case Management (Private)	*1/4 hour*	*1000*	*14.00*	*15.84*	***221760.00***	
Case Management (Public)	*1/4 hour*	*3825*	*14.00*	*38.63*	***2068636.50***	
Homemaker Total:						***2944406.25***
Homemaker	*1/4 hour*	*1083*	*435.00*	*6.25*	***2944406.25***	
Respite Total:						***1723950.00***
Respite per diem	*per diem*	*5*	*1.00*	*150.00*	***750.00***	
Respite per unit	*1/4 hour*	*384*	*718.00*	*6.25*	***1723200.00***	
Adult Companion Total:						***315900.00***
Adult Companion	*1/4 hour*	*117*	*432.00*	*6.25*	***315900.00***	
Adult Day Care Total:						***589501.50***
Adult Day Care per diem	*per diem*	*128*	*109.00*	*42.00*	***585984.00***	
Adult Day Care per unit (1/4 hour)	*1/4 hour*	*6*	*335.00*	*1.75*	***3517.50***	
Augmented Personal Care (APC) Total:						***63395938.76***
APC Level of Service 1 (U1)	*per diem*	*275*	*196.00*	*68.75*	***3705625.00***	
APC Level of Service 2 (U2)	*per diem*	*646*	*187.00*	*103.13*	***12458310.26***	
APC Level of Service 3 (U3)	*per diem*	*673*	*185.00*	*137.50*	***17119437.50***	
APC Level of Service 4 (U4)	*per diem*	*506*	*478.00*	*124.50*	***30112566.00***	
Chore Total:						***4593.75***

GRAND TOTAL:	***80742340.76***
Total Estimated Unduplicated Participants:	***5057***
Factor D (Divide total by number of participants):	***15966.45***
Average Length of Stay on the Waiver:	*288*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Chore	1/4hour	35	35.00	3.75	4593.75	
Home Delivered Meals Total:						8530494.00
Home Delivered Meals	Per Meal	2758	300.00	10.31	8530494.00	
Personal Emergency Response System (PERS) Total:						947160.00
PERS (monthly)	per month	2559	9.00	40.00	921240.00	
PERS Installation	1 system	576	1.00	45.00	25920.00	

GRAND TOTAL:	80742340.76
Total Estimated Unduplicated Participants:	5057
Factor D (Divide total by number of participants):	15966.45
Average Length of Stay on the Waiver:	288