372 - Annual Report on Home and Community-Based Services Waivers

State:	**NV**
Waiver Base:	**0152**
Report Status:	**ACCEPTED**
Begin Date:	07/01/2016
End Date:	06/30/2017
Initial Submission Date:	12/24/2018
Report Period Year:	2017
Waiver Year:	○ **Year 1** ◉ **Year 2** ○ **Year 3** ○ **Year 4** ○ **Year 5**
Report Type:	○ **Initial Report** ◉ **Lag Report** ○ **TE Report**
Unduplicated Participants:	2,508
Days of Waiver Enrollment:	695,201
Average Length of Stay:	277.2
Total Waiver Expenditures:	$12,400,255.00
APC Waiver Services (Factor D):	4,944
APC for State Plan Services (D'):	4,567
APC Total (D + D'):	$9,511
Factor G Value:	64,317
Factor G' Value:	15,486
APC Total if no waiver (G + G'):	$79,803
D + D' <= G + G':	**$9,511 <= $79,803**
Level/s of Care:	☐ **ICF/IID** ☒ **NF** ☐ **Hospital**

Additional Information (use if needed):

The Division of Health Care Financing and Policy (DCHFP) exercises administrative authority over the operation of the Home and Community Based Services (HCBS) Waiver (HCBW) for the Frail Elderly (FE)and issues policies, rules, and regulations related to the FE Waiver. The Aging and Disability Services Division (ADSD) is the operating agency for the FE Waiver.

Providers under the HCBS Waiver for the FE direct bill DHCFP's QIO-like vendor for payment. The ADSD performs service authorizations as an administrative function of the waiver. These authorizations include scope, frequency, type, amount and duration of services.

Private case management was not utilized during the waiver period due to lack of qualified providers enrolled as Medicaid providers.

This waiver remains cost neutral.

Note: Average Per Capita (APC)

Annual Number of Section 1915c Waiver Recipients and Expenditures:
(Specify each service as in the approved waiver)

Service

Service Name (required field):	Level of Care	Participants	Service Category Name
◉ Expenses in $ ○ Expenses in % $810,317	NF	2,421	Category: trained support, training, consumer preparation, educational services

HCBS Taxonomy:

Category 1: Subcategory 1:
Category 2: Subcategory 2:
Category 3: Subcategory 3:
Category 4: Subcategory 4:

Service Name (required field):	Level of Care	Participants	Service Category Name
◉ Expenses in $ ○ Expenses in % $770,142	NF	506	Category: homemaker

HCBS Taxonomy:

Category 1: Subcategory 1:
Category 2: Subcategory 2:
Category 3: Subcategory 3:
Category 4: Subcategory 4:

Service Name (required field):	Level of Care	Participants	Service Category Name
◉ Expenses in $ ○ Expenses in % $312,830	NF	200	Category: respite, caregiver or family supports, family education

HCBS Taxonomy:

Category 1: Subcategory 1:
Category 2: Subcategory 2:
Category 3: Subcategory 3:
Category 4: Subcategory 4:

Service Name (required field):	Level of Care	Participants	Service Category Name
◉ Expenses in $ ○ Expenses in % $38,508	NF	52	Category: day care, adult day health

HCBS Taxonomy:

Category 1: Subcategory 1:
Category 2: Subcategory 2:
Category 3: Subcategory 3:
Category 4: Subcategory 4:

Service Name (required field):	Level of Care	Participants	Service Category Name
Alternative service title and other information: **Installation** ◉ Expenses in $ ○ Expenses in % $730,678	NF	139	Category: emergency response, crisis stabilization, personal monitoring system, telephone alert, PERS

HCBS Taxonomy:

Category 1: Subcategory 1:

Service

Category 2: Subcategory 2:
Category 3: Subcategory 3:
Category 4: Subcategory 4:

Service Name (required field):	Level of Care	Participants	Service Category Name
Personal Emergency Response System (PERS) Installation ◉ Expenses in $ ○ Expenses in % $13,850	NF	304	Category: emergency response, crisis stabilization, personal monitoring system, telephone alert, PERS

HCBS Taxonomy:

Category 1: Subcategory 1:
Category 2: Subcategory 2:
Category 3: Subcategory 3:
Category 4: Subcategory 4:

Service Name (required field):	Level of Care	Participants	Service Category Name
Personal Emergency Response System (PERS) Ongoing (Monthly) ◉ Expenses in $ ○ Expenses in % $406,896	NF	1,150	Category: personal care, in-home supports, attendant care, in-home aide, personal assistance, night supervision

HCBS Taxonomy:

Category 1: Subcategory 1:
Category 2: Subcategory 2:
Category 3: Subcategory 3:
Category 4: Subcategory 4:

Service Name (required field):	Level of Care	Participants	Service Category Name
Augmented Personal Care (APC) ◉ Expenses in $ ○ Expenses in % $9,309,625	NF	937	Category: chore, home maintenance, support maintenance

HCBS Taxonomy:

Category 1: Subcategory 1:
Category 2: Subcategory 2:
Category 3: Subcategory 3:
Category 4: Subcategory 4:

Service Name (required field):	Level of Care	Participants	Service Category Name
Chore ◉ Expenses in $ ○ Expenses in % $7,408	NF	40	Category: companion, escort services

HCBS Taxonomy:

Category 1: Subcategory 1:
Category 2: Subcategory 2:
Category 3: Subcategory 3:
Category 4: Subcategory 4:

Assurances:

1. ☒ **Assurances were submitted with the initial report. (If you are submitting a lag report this item must be checked.)**
2. ☒ **All provider standards and health and welfare safeguards have been met and corrective actions have**

been taken where appropriate

3. ☒ **All providers of waiver services were properly trained, supervised, and certified and/or licensed, and corrective actions have been taken where appropriate.**

Documentation:

4. Provide a brief description of the process for monitoring the safeguards and standards under the waiver:

The Division of Health Care Financing and Policy (DHCFP) and the Aging and Disability Service Division (ADSD) meet quarterly to discuss quality measures, remediation activities, training opportunities and program operations.

As the operating agency, the ADSD tracks serious occurrences on an ongoing basis and reports quarterly to the DHCFP. The Serious Occurrence Reports (SOR) are reviewed and followed up on by the ADSD Case Managers and/or supervisory staff. During the Waiver Year 2017 the following SORs were reported:

SORs July 1, 2016 to June 30, 2017:

Serious Occurrence Event Types:	Total:
Unplanned Hospital Admission/ER visit	1360
Injury/Fall	498
Alleged Assault/Abuse/Neglect	51
Suicidal Threat/Attempt	8
Criminal Activity	1
Theft/Exploitation	21
Medication Error	55
Loss of Contact/Elopement	13
Death of recipient	250

There were fifty-one (51) SORs reported under the Alleged Assault /Abuse/Neglect during this reporting period, twenty-one (21) cases were tracked under Theft/Exploitation. These cases were referred to Elder Protective Service (EPS) for further investigations, EPS determines if cases are substantiated or un-substantiated; however, due to confidentiality regulations EPS can not provide detailed information on the outcome for each SOR. Once EPS conducts their investigation they report to the ADSD the cases have been completed and no further details are provided.

The ADSD tracks the number of applicants on the wait list and wait time until placement, which is the time from referral to program eligibility. The ADSD allocates the waiver slots based on priority. The DCHFP monitors the unduplicated count monthly and waiver expenditure data quarterly.
The DHCFP reviews 100% of all intake packets for completeness and conducts a content review of 25% prior to approval.
The DHCFP sends all Notices of Decision (NODS) on all waiver denials, suspensions, and terminations.

Hearings:
The DHCFP Compliance Unit monitors hearing and appeals for waiver services. During waiver year 2017, the DHCFP received four (4) hearing requests.
The results of the hearing requests are as follow: two (2) of the request requests were withdrawn by Petitioner (no Hearing Preparation Meeting)- the waiver services were reinstated and the recipients withdrew the Fair Hearings Requests (FHR); 1 request withdrawn by petitioner (no HPM)- the recipient withdrew the FHR after the Notice of Decision was explained; 1 request was dismissed with prejudice - the HPM was conducted and the recipient proceeded to Fair Hearing. Prior to the Hearing, the recipient was re-assessed and determined to meet the criteria for the FE Waiver. The services were reinstated and the Hearing Officer dismissed with prejudice.

Claims:
Direct Service Case Management and Administrative Case Management are billed and tracked separately. The Case Managers, supervisors and/or administrative assistants review case management billing workbooks prior to submitting claims for case management expenditures.
The Medicaid Management Information System (MMIS) claims processing system identifies the provider, authorized services, rate and units of service for each recipient. The system is linked to the Medicaid eligibility system, which checks each claim to ensure recipients were eligible on the dates of services. The system maintains records on both the recipient and the provider.
The ADSD maintains a record on each recipient documenting the recipient's waiver eligibility and approved services. The record includes recipient demographics, assessments, level of care screenings, Plan of Care, and documentation of all case management provided. These records are reviewed during supervisory reviews and the DHCFP's monthly quarterly reviews.

Findings of Monitoring:

5. ☐ **No deficiencies were detected during the monitoring process;**
6. ☒ **Deficiencies were detected.**
   Provide a summary of the significant areas where deficiencies were detected, (Note: Individual reports or assessment forms for waiver individuals and/or providers disclosing deficiencies and which document the summary are not necessary):

The Division of Health Care Financing and Policy (DHCFP) has a Quality Assurance (QA) Unit assigned specifically to review waiver programs. The Annual Statewide Consolidated Review for the Home and Community Based Services (HCBS) Waivers for the Frail Elderly (FE) and Persons with Physical Disabilities (PD) for the State of Nevada, was conducted over a period from July 2016 to June 2018. A combined random sample of three hundred fifty-eight (358) Case Files were reviewed, one hundred and seventy-six (176) Financial Reviews were completed from ninety-four (94) recipients and one hundred and fifty-seven (157) recipients were selected for Participant Experience Surveys (PES) for 2016-2018 waiver year.

To avoid duplication of efforts, reviews conducted by the ADSD staff were obtained for a portion of the case file reviews and the PES. All provider reviews were completed by the ADSD.

Case File Reviews:
The Case File Review focused on five (5) key areas: Level of Care (LOC), Comprehensive Social Health Assessment (CSHA), Plan of Care (POC), Forms, Monthly Contacts and Documentation.

Statewide Case File Review Results:

Meets LOC 99%
LOC score is accurate 100%
LOC completed annually 99%
CSHA reviewed every 6 months (PD ONLY) 67%
Contact made within 15 days of referral (FE ONLY) 93%
IA/LOC completed within 45 days 93%
Needs identified on CSHA reflected on POC 87%
Personal goals on CSHA are on POC (PD ONLY) 98%
Personal goals identified on POC (FE ONLY) 98%
Risks identified on CSHA are addressed on POC 95%
Frequency/Duration/Scope of services 86%
Services on the POC have a PA 96%
Service level identified (FE ONLY) 95%
POC signed by recipient within 60 days 77%
POC signed by provider within 60 days 67%
POC updated within 30 days (New PD ONLY) 87%
POC revised as needed 82%
POC completed annually 85%
POC reviewed at home visits 61%
SOU signed by recipient 94%
Recipient Rights reviewed 93%
Preventative health care info provided (FE ONLY) 87%
Monthly contacts 98%
Face-to-Face 96%
Health and safety issues identified and followed up 97%
Needs and concerns followed up 96%
Waiver service satisfaction assessed monthly 97%
Personal goals assessed monthly 97%

Financial Reviews:

The Financial Reviews focused on four(4) key areas: Waiver Eligibility, Prior Authorizations, Daily Records, Payments.

Statewide Financial Review Results:

Enrollee eligible on the date of service 99%
Are there conflicting services provided during the review month/service date (Institutional Care) 99%
Is Service prior authorized 100%

Correct provider type 98%
Service date(s) billed match date(s) services were provided 96%
Procedure Code/Modifier /service level correct 99%
Service units billed fall within the PA units allowed 98%
Is the amount billed correct 95%
Services provided match the POC 94%
Frequency of services match the POC 85%
Service units/days provided match units/days billed and for which payment was received 94%
Daily log signed/initialed by recipient 95%
Daily log signed/initialed by provider/staff 97%
If applicable, documented in POC that recipient is unable to sign due to cognitive and/or physical limitations 98%
Payment to provider correct based on claim submitted 89%
Services paid according to Medicaid allowable rate 99%
Claims resulting in an overpayment to the provider 12%
Claims referred to the Surveillance and Utilization (SUR) Unit 12%
Is the provider eligible for payment (active) 100%

Participant Experience Surveys (PES):

The PES review focused on four (4) key areas: Access to Care, Choice and Control, Respect/Dignity, Community Integration/Inclusion.
This was the first year that the PES interviews were conducted monthly starting in July 2017 and ending June 2018. Three hundred fifty-eight (358) recipients were selected to meet a 95/5 sample size. PES interviews conducted by the ADSD staff made up two hundred and sixty-five (265) PES interviews, with a 95/10 sample of ninety-three (93) recipients interviewed by the DHCFP QA staff. Out of the ninety-three (93) recipients, fifty-six (56) were interviewed face-to-face by the DHCFP QA staff; and thirty-seven (37) recipients did not participate either by choice, or due to circumstances such as hospitalization or their waiver case being closed.

7. ☒ **Deficiencies have been, or are being corrected.**
Provide an explaination of how these deficiencies have been, or are being corrected as well as an explanation of what steps have been taken to ensure the deficiencies do not recur:

For the 2016-2018 review year, based on chart reviews, the following elements have been identified as needing further analysis by the Quality Improvement (QI) team:

CSHA reviewed every six (6) months (PD ONLY): 67% of the PD case files reviewed, did not indicate that the CSHA was reviewed with the recipient during face-to-face home visits.
Due to the PD waiver renewal being approved at the end of the reporting year 07/01/2018, the above requirement was removed and will no longer be applicable in future reviews

Frequency/Duration/Scope: 86% of the case files reviewed were missing scope for at least one (1) service listed on the POC. Recommendation: At this time the Social Assistance Management Software (SAMS) system does not include a subservice section for seven (7) of the services provided by the ADSD. During the 07/2016 QI meeting it was decided that this requirement will be mitigated by including the scope of service in the notes or desired outcomes section of the POC for the following services: PERS, PERS Installation, Home Delivered Meals, Attendant Care Services, Adult Day Care, Respite and Environmental Adaptations.
POC signed by recipient within sixty (60) days: 77% of the POCs reviewed were either not signed or not signed within the required timeframe by the recipient or their designated representative.
Recommendation: Use a calendar alert system, within SAMS if possible, for time-sensitive documents. This will allow the case managers to recognize what items need action on any given date.

POC signed by provider within sixty (60) days: 67% of the POCs reviewed were either not signed or not signed within the required timeframe by the provider. Recommendation: Use a calendar alert system, within SAMS if possible, for time-sensitive documents. This will allow the case manager to recognize what items need action on any given date.

POC revised as needed: 82% of the POCs reviewed were not updated as needed when the Case Manager noted a change in health or services were needed to be addressed with the recipient.
Recommendation: If documenting a change with the recipient or needed services when narrating the monthly contact, a new POC should be created at that time and sent to the recipient for signature.

POC completed annually: 85% of the POCs reviewed were not completed annually within the same month. Recommendation: Use a calendar alert system, within SAMS if possible, for time-sensitive documents. This will allow the Case Manager to recognize what items need action on any given date.

POC reviewed at home visits: 61% of the case files reviewed did not validate that the POC was reviewed with the recipient at the face-to-face visit. Recommendation: Take a copy of the current POC to the face-to-face visits to ensure that the POC is readily accessible to review with the recipient. In order for the DHCFP QA staff to validate that this requirement was met, it must be clearly documented in the narrative for the face-to-face visit.

Financial Review, following elements have found to be deficient:
Frequency of services match the POC 85% Recommendation: At this time the Social Assistance Management Software (SAMS) system does not include a subservice section for seven (7) of the services provided by the ADSD. During the 07/2016 QI meeting it was decided that this requirement will be mitigated by including the scope of service in the notes or desired outcomes section of the POC

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

Is Service prior authorized: 1%
Correct provider type: 2%
Services date(s) billed for match the date(s) services were provided: 7%
Services provided match the POC: 9%
Service units/days provided match units/days billed and for which payment was received: 7%
Service units billed for fall within the PA units allowed: 1%
Daily log signed/initialed by recipient: 7%
Daily log signed/initialed by provider/staff: 7%

Payment to provider correct based on claim submitted: 11%
Is the provider eligible for payment (active): 1%
Claims resulting in an overpayment to the provider: 11%
Claims referred to the SUR unit: 6%

Elements with no change since last review period:

Is the amount billed correct.
Frequency of services match the POC

The following elements showed a decrease from the previous review period:

Enrollee eligible on the date of service: 1%

Are there any conflicting services provided during the review month/service date (Institutional Care): 1%
Procedure code/modifier/service level correct: 1%
Documented in POC recipient is unable to sign: 1%
Services paid according to the Medicaid allowable rate: 1%

Financial review results are a reflection of compliance for the provider community. Two (2) elements of the review resulted in a one percent (1%) improvement when compared to the 2015-2017 combined average results. Seven (7) elements resulted in a one percent (1%) or more decrease in compliance when compared to the 2015-2017 review period combined average results. The data element, “Frequency of services match the POC” was the only performance measure that fell below the eighty-six percent (86%) threshold, resulting in eighty-five percent (85%) compliance. "Claims resulting in an overpayment" and "Claims referred to Surveillance and Utilization (SUR) Unit" showed a decrease of eleven percent (11%) and six percent (6%) respectively. Lower percentages for these two (2) elements signify that fewer cases were referred to the SUR Unit for overpayment.

There were a total of fourteen (14) cases referred to SUR as a result of the Consolidated Annual Review. Once the SUR Unit receives the referrals, these are assigned to their staff for further review. If the staff discovers a Quality of Care issue, a referral is made to the correct entity such as Elder Protective Services. Many of the referrals result in a “No deficiency” and the referrals are closed and no further action are taken. For referrals when a Policy Non-Compliance issue is identified an Education Letter is sent to the provider including the “Policy Acknowledgement Form” for the provider to sign, date and return to SUR. The SUR Unit retains this letter on their records. Referrals that result in an overpayment, the SUR Unit will mail a Preliminary Findings Letters, which allows provider the opportunity to discuss the claims in question and ask for clarification. Once the providers understand and agrees, the SUR Unit refers the overpayments to the DHCFP Recovery Unit for the debt collection, once the Final Recoupment letter is sent to with the Educational Letter SUR is done and the Recovery Unit is responsible for collecting the recoupment.

As of 12/2018, the SUR Unit provided the following updates: one (1) case resulted "Closed- No Further Action", five (5) cases resulted on "Recoupment & Educational Letter", the recoupment totaled $2915.00; one (1) case resulted in "Educational Letter"; seven (7) cases are currently under review under the Preliminary stage investigation.

All elements with a decrease in compliance will be addressed in the forthcoming QI meetings in an effort to improve the overall operation of the HCBS FE/PD Waivers.

Comprehensive Provider Review:

The DHCFP and the ADSD combined efforts to create the ALiS provider database, which went live in March of 2018 Providers can log in and see the results of their review, along with submitted electronic Plans of Improvement (POI) through their individualized, secure login. A Comprehensive HCBS Provider Review form was created in addition to the database that ensures all the appropriate information is being captured in a concise and consistent manner. Furthermore, the implementation of the database and

comprehensive form will eliminate duplication of efforts as each agency that conducts a provider review has the necessary tools to complete reviews for all of the provider type services being offered by the selected provider, eliminating the need for a second agency to go out and conduct the same review.

Participant Experience Surveys:

A focus of the HCBS Waiver Program(s) is to ensure the recipient is satisfied with their services and achievement of desired outcomes. Recipients were interviewed regarding their experiences and satisfaction with their waiver services and providers. The interviews were conducted by the DHCFP QA staff and the ADSD staff using the Participant Experience Survey (PES) interview tool developed by The MEDSTAT Group, Inc. under a contract from the CMS. Indicators used for monitoring quality within the waiver program(s) are calculated using the data captured from these surveys.

The DHCFP QA staff used the person-centered approach when scheduling PES interviews to ensure the recipient focused and met with the recipients at a location of the recipient's choosing such as their home, group home or adult day care. Family, support staff or a designated representative may have been present during the interview; however, the results of the surveys reflect the recipients' own answers whenever possible. If an individual other than the recipient answered any questions, it is noted on the PES interview tool. Some recipients may not be able to respond to some or all of the questions listed on the PES interview tool due to cognitive and/or physical limitations.
Recipient issues determined to be critical and in need of immediate attention were promptly communicated to the appropriate ADSD office staff.
The top nine (9) questions with the highest recipient satisfaction are:
Directing Staff
POC Development
Respect by Day Program Staff
Community Involvement
Choice in Employment
Satisfaction with Employment
Demand of Employment
Case Manager Helpfulness

The four (4) questions with the highest adverse responses indicating an unmet need are:
Choice in Staff
Ability to Identify Case Manager
Equipment or Modifications
Transportation

The DHCFP QA staff understands that due to the nature of the population interviewed, inconsistencies were noted in responses from the HCBS FE/PD Waiver recipients. A number of recipients indicated that they did not know who their case manager is; however, the person who calls every month or even more frequently is nice and helpful.
This may contribute to why the "Ability to Identify Case Manager" is listed as an unmet need. In addition to the questions that were asked, the following positive feedback was provided by recipients and/or their family members or designated representative. The recipients clearly expressed their satisfaction with their Case Manager as well as with their providers.

Out of the fifty-six (56) recipients interviewed face-to-face by the DHCFP QA it is unknown how many recipients had issues getting Equipment or Modifications; even though Equipment modification is not covered benefit under the FE Waiver, waiver recipients have access to this service under the State Plan; also, the ADSD Case Managers placed waiver recipients within the ADSD's Program for Seniors or find other resources available within the community if the need cannot be alleviated through waiver services.

Even though transportation is not covered under the FE Waiver, waiver recipients have access to transportation under the State Plan; also, the ADSD Case Managers coordinate that waiver recipient utilize all available resources in the community. For recipients residing in a Group Home or Assisted Living, the facility assists with all transportation needs. Recipients are able to discuss their concerns with their Case

Manager as well as providers, promptly resolving any conflicts or issues with their services and/or staff.

Recipients, family members and/or designated representatives reported that the ADSD person-centered planning approach to selecting and providing services included a broad view of the recipient's desires.

Certification:

I, do certify that the information shown on the Form CMS-372(S) is correct to the best of my knowledge and belief:

Signature: Kirsten Coulombe **Date:** 12/24/2018

Contact Information (optional):

Contact Person:

Phone Number:

PRA Disclosure Statement

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