MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

June 27, 2023

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: CASEY ANGRES
CHIEF OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 2300 – HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER FOR PERSONS WITH PHYSICAL DISABILITIES

## BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 2300 – HCBS Waiver for Persons with Physical Disabilities (PD) are being proposed to align this chapter with the current waiver renewal which was approved by the Centers for Medicare and Medicaid Services (CMS) on January 1, 2023, and to bring the Person-Centered Planning process into compliance with the HCBS Settings Requirements (42 CFR 441.301(c)(1) through (c)(5)).

Major proposed changes to this chapter include the addition of Legally Responsible Individuals (LRI) to the pool of paid caregivers for the provision of personal care-like services, addition of Private Case Management (PCM) provider, modifications to the waiver slot wait list, transferring of the disability determination process to MSM Chapter 2300 from Medicaid Operations Manual (MOM) Chapter 1000 that will be obsolete, and modification to the Homemaker Waiver service Coverage and Limitations.

Throughout the chapter, grammar, punctuation and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

Entities Financially Affected: None.

Financial Impact on Local Government: Unknown at this time.

These changes are effective June 28, 2023.

| MATERIAL TRANSMITTED | MATERIAL SUPERSEDED |
|---|---|
| MTL OL<br>CHAPTER 2300-HOME AND<br>COMMUNITY BASED SERVICES | MTL 08/13,<br>CHAPTER 2300-HOME AND<br>COMMUNITY BASED SERVICES |

| Manual Section | Section Title | Background and Explanation of Policy Changes, Clarifications and Updates |
|---|---|---|
| **2300** | **Introduction** | Terminology and acronyms were updated and reworded for clarity and continuity.<br><br>The second paragraph was deleted and replaced with a reworded version that better reflects an overview of the waiver.<br><br>Several sentences were moved from sections of 2301 and modified for clarity. |
| **2301** | **Authority** | Terminology and acronyms were updated and reworded for clarity and continuity.<br><br>Some statutes and regulations were removed and/or updated to align with current Federal and State regulations as applicable:<br><br>Removed SSA 1916 (e) and 1902 (w), Omnibus Budget Reconciliation Act of 1987, Balanced Budget Act of 1997, State Medicaid Manual Section 44442.3.B.13, State Medicaid Director Letter (SMDL) #01-006 attachment 4-B, and Title 42, CFRs Part 441, 431 and 489.<br><br>Added NRS Chapters 200, 426, and 427A, 422, 449, 616, 706, and 446.<br><br>Added NRS 449.A.114 – Patient Notification of Intent to Transfer.<br><br>Removed NAC chapters 441A.375 and 706.<br><br>Added Section 3715 of The Coronavirus Aid, Relief, and Economic Security (CARES) Act.<br><br>Added CFR 435.540 (Definition of Disability) and 441.301(c)(1) through (c)(5) (Federal Person-Centered Planning and Settings Requirements).<br><br>Removed H.R. 6042 – 115th Congress. |
| **2303.1** | **Waiver Eligibility Criteria** | This section was moved and renumbered from 2303.2 to 2303.1 and subsequent sections numbered accordingly. |

| Manual Section | Section Title | Background and Explanation of Policy Changes, Clarifications and Updates |
|---|---|---|
| | | Terminology and acronyms were updated and reworded for clarity and continuity.<br>Added new sections outlining PD Waiver eligibility criteria to #A through #G. |
| **2303.1A** | **Coverage and Limitations** | This section was moved and renumbered from 2303.2A to 2303.1A.<br><br>Terminology and acronyms were updated and reworded for clarity and continuity.<br><br>Removed #2 as it is duplicative to 2303.1.<br><br>Added #3 to indicate services will only be reimbursed for eligible recipients and services must be prior authorized.<br><br>Added #4 indicating individuals found eligible for more than one waiver program must choose one.<br><br>Added #5 indicating waiver recipients may enroll in hospice and remain on the waiver if they choose.<br><br>Added #6 indicating that Section 3715 of the CARES Act may be utilized and included additional clarifications.<br><br>Removed original #6 indicating HCBS services are not a substitute for natural and informal supports. |
| **2303.1B** | **Disability Determination** | Created a new section outlining disability determination process for new PD Waiver applicants. Medicaid Operations Manual (MOM) Chapter 1000 will be obsoleted and combined to this section. |
| **2303.1C** | **Applicant/Recipient Responsibilities** | Created new section outlining recipient responsibility to become eligible and receive waiver services. |
| **2303.2** | **Waiver Services** | This section was moved and renumbered from 2303.3 to 2303.2 and subsequent sections numbered accordingly.<br><br>Terminology and acronyms were updated and reworded for clarity and continuity. |

| Manual Section | Section Title | Background and Explanation of Policy Changes, Clarifications and Updates |
|---|---|---|
| **2303.2A** | **Coverage and Limitations** | This section was renumbered from 2303.3A to 2303.2A.<br><br>Terminology and acronyms were updated and reworded for clarity and continuity.<br><br>Services rearranged to follow the order they are listed within the current approved Waiver application as well as the order in which they are listed within this chapter. |
| **2303.2B** | **Provider Responsibilities** | This section was renumbered from 2303.3B to 2303.2B.<br><br>Terminology and acronyms were updated and reworded for clarity and continuity.<br><br>Changed language under #1 to indicate that all providers must obtain a provider number (PT 58) through DHCFP's Fiscal Agent. Removed requirement for providers to verify recipient's Medicaid eligibility as it is duplicative to other sections of this chapter.<br><br>Added #2 to state that providers must meet all statutes, rules and regulations related to service being provided.<br><br>Reworded #3 and added additional language to indicate that a provider's contract may be terminated if they fail to comply with all rules and regulations.<br><br>Added #4 to include reasons a provider may terminate services as well notification requirements when a provider terminates services.<br><br>Added #5 regarding "Discontinuation of Provider Agreement".<br><br>Revised language in #6 to be more concise regarding POC, billing procedures and record keeping responsibilities.<br><br>Added "Flexibility of Service Delivery" to #7 regarding total authorized hours. |

| Manual Section | Section Title | Background and Explanation of Policy Changes, Clarifications and Updates |
|---|---|---|
| | | Added #8 indicating providers are responsible for any claims/payments received on the recipient's behalf.<br><br>Added #9 instating providers must understand payment for services are based on POC.<br><br>Revised language in #10 to indicate that LRIs can be paid for some direct waiver services and included additional information regarding payment of services to Legally Responsible Individuals.<br><br>Added #11 indicating providers may only provide services identified on POC/have a prior authorization if required.<br><br>Added #12 indicating providers must have a backup mechanism in place.<br><br>Added #13 outlining the timeframe by which providers must sign and date the finalized POC.<br><br>Revised language in #14 detailing Serious Occurrence reports and created new sections detailing both public (ADSD) and private case management reporting requirements for SORs.<br><br>Removed language detailing criminal background checks and created new updated section #15 and a portion removed as it is outlined in MSM 100 and is duplicative.<br><br>Added #16 regarding recipient record requirements for all providers.<br><br>Added #17 indicating all providers must adhere to HIPAA requirements.<br><br>Added #18 stating that providers must maintain a business license, if applicable.<br><br>Added #19 indicating providers must also obtain HCQC licensure, if required.<br><br>Removed "Provider Agencies" section and replaced with new section titled "Qualifications and Training" #20 outlining all training requirements for providers. |

| Manual Section | Section Title | Background and Explanation of Policy Changes, Clarifications and Updates |
|---|---|---|
| | | Removed section for exemptions from training for Provider Agencies as not applicable to current requirements.<br>Removed "Recipients Providing Training" section.<br><br>Removed "Completion and Documentation of Training" section.<br><br>Removed information regarding TB testing as this is outlined in HCQC provider requirements. |
| **2303.2C** | **Recipient Responsibilities** | This section was renumbered from 2303.3C to 2303.2C.<br><br>Terminology and acronyms were updated and reworded for clarity and continuity.<br><br>Added #2 requiring recipients to notify providers/DWSS or current insurance information.<br><br>Added criteria of required environment for providers and staff to #4.<br><br>Added language to #5 that provider records must be dated along with signature. Included clarification in the event the recipient is unable to sign documents.<br><br>Added requirement to #10 to work with case manager and provider to create a back-up plan in case caregiver is unavailable to work.<br><br>Added requirement that all forms be signed by recipient within 10 calendar days to #15.<br><br>Added #16 requirement for annual face-to-face visit.<br><br>Added requirement that recipient be physically available to #17 and removed section indicating the recipient must meet and maintain all eligibility criteria.<br><br>Removed section regarding patient liability as this does not pertain to Waiver recipients. |

| Manual Section | Section Title | Background and Explanation of Policy Changes, Clarifications and Updates |
|---|---|---|
| | | Added #20 indicating that recipients have the right to actively participate in the person-centered planning process and what must be included in the process. |
| **2303.3** | **Intake Activities** | Created new section titled "Intake Activities" to detail the intake functions completed by the ADSD Operations Agency. |
| **2303.3A** | **Coverage and Limitations** | Added updated Intake Referral process for new applicants for the PD Waiver program.<br><br>New process for placing applicants on the waitlist and new waitlist priority levels 1-4 updated/added.<br><br>Created a new process for waiver slot allocation.<br><br>Added information on effective date for waiver services once a waiver slot is available.<br><br>Added information about recipient right to choose ADSD case manager or private case management agency and process for assigning case management agency once the recipient has chosen and placed on the waiver. |
| **2303.4** | **Case Management** | This section was renumbered from 2303.3D to 2303.4 and subsequent sections renumbered accordingly. Removed "Direct Service" from section title.<br><br>Added summary description for case management service. |
| **2303.4A** | **Coverage and Limitations** | This section was renumbered from 2303.3E to 2303.4A.<br><br>Terminology and acronyms were updated and reworded for clarity and continuity.<br><br>Paragraph added summarizing case management service responsibilities.<br><br>Added Section detailing administrative case management activities and additional section detailing billable case management activities. |

| Manual Section | Section Title | Background and Explanation of Policy Changes, Clarifications and Updates |
|---|---|---|
| | | Created new sections outlining the initial assessment process, social health assessment, development of the person-centered Plan of Care, changes to the Plan of Care, Plan of Care modifications for individuals in an assisted living facility, person-centered contacts, annual reassessments, and other responsibilities to be completed by the case management provider.<br><br>Added #12 indicating how a recipient can request to change case management providers. |
| **2303.4B** | **Provider Responsibilities** | This section was renumbered from 2303.3F to 2303.4B. Removed "Direct Services Case Management" from the title.<br><br>Terminology and acronyms were updated and reworded for clarity and continuity.<br><br>Incorporated case management provider requirements and additional requirements for private case management providers.<br><br>Removed paragraph indicating case management licensure requirements. |
| **2303.4C** | **Recipient Responsibilities** | This section was renumbered from 2303.3G to 2303.4C.<br><br>Terminology and acronyms were updated and reworded for clarity and continuity.<br><br>Language updated to be more concise.<br><br>Updated language in #1 from 'monthly' to 'ongoing' contacts as outlined within current waiver application.<br><br>Removed sentence regarding provider initials on daily records as this does not pertain to case management.<br><br>Updated language in #3 to state recipient must choose a Medicaid enrolled case management provider. |
| **2303.5** | **Homemaker Services** | This section was renumbered from 2303.4 to 2303.5 and subsequent sections renumbered accordingly. |

| Manual Section | Section Title | Background and Explanation of Policy Changes, Clarifications and Updates |
|---|---|---|
| | | Added summary paragraph detailing what is available under Homemaker services and specified that homemaker services are not available to individuals receiving State Plan personal care services. |
| **2303.5A** | **Coverage and Limitations** | This section was renumbered from 2303.4A to 2303.5A.<br><br>Terminology and acronyms were updated and reworded for clarity and continuity.<br><br>The following language was added to #1, "at the recipient's home, or place of residence (community setting)" and removed "by agencies enrolled as a Medicaid provider."<br><br>Removed sentence from #2 regarding temporary absence/unable to manage home for more concise language.<br><br>Updated language in #3 indicating DHCFP/Fiscal Agent are not responsible for damaged goods during the provision of service.<br><br>Updated descriptions of homemaker services provided to #4 for more clarity and consistency.<br><br>Updated language to #5 indicating what services are not approved under homemaker.<br><br>Added #6 indicating paid LRIs may provide this service and included service limitations. |
| **2303.5B** | **Provider Responsibilities** | This section was renumbered from 2303.4B to 2303.5B.<br><br>"Homemaker" was removed from the section title.<br><br>Terminology and acronyms were updated and reworded for clarity and continuity.<br><br>Revised language in #1 to be more concise and indicate specific training requirements for PD recipients. |

| Manual Section | Section Title | Background and Explanation of Policy Changes, Clarifications and Updates |
|---|---|---|
| | | Removed #2 stating a LRI cannot be paid for homemaker services.<br><br>Removed #3 indicating DHCFP is not responsible for damaged goods as this is repetitive.<br><br>Added sentence stating that service must be prior authorized and documented in an approved EVV system. |
| **2303.5C** | **Recipient Responsibilities** | Created new Recipient Responsibility section.<br><br>Included information regarding recipient's responsibility to utilize an approved EVV system as well as to provide confirmation that services were received via signature/IVR. |
| **2303.6** | **Respite Care** | This section was moved, but numbering remains the same.<br><br>Added description paragraph of what services may be included under Respite Care to provide clarity and consistency. |
| **2303.6A** | **Coverage and Limitations** | Terminology and acronyms were updated and reworded for clarity and continuity.<br><br>Updated time frame in which respite services may be provided to 24-hour periods.<br><br>Updated #2 to reflect language in current waiver application stating respite care is limited to 120 hours for the duration of the Plan of Care.<br><br>Added sentence stating that services must be prior authorized by Case Management provider. |
| **2303.6B** | **Provider Responsibilities** | Removed "Respite Care" from the title of this section.<br><br>Terminology and acronyms were updated and reworded for clarity and continuity.<br><br>Removed requirement to perform general assistance it ADLs and IADLs as this is duplicative to Coverage and Limitations. |

| Manual Section | Section Title | Background and Explanation of Policy Changes, Clarifications and Updates |
|---|---|---|
| | | Revised language in #1 to be more concise and indicate specific training requirements for PD recipients.<br><br>Removed sentence indicating providers must demonstrate the ability to perform the care tasks.<br>Removed language in #3 as this information is stated under 2303.2B.<br><br>Added sentence stating that service must be prior authorized and documented in an approved EVV system. |
| **2303.6C** | **Recipient Responsibilities** | This section was added for consistency.<br><br>Included information regarding recipient's responsibility to utilize an approved EVV system as well as to provide confirmation that services were received via signature/IVR. |
| **2303.7** | **Attendant Care Services** | This section was moved and renumbered from 2303.12 to 2303.7 and subsequent sections renumbered accordingly. "Services" was added to title for consistency and clarity.<br><br>Added service definition as detailed within the waiver application. |
| **2303.7A** | **Coverage and Limitations** | Section moved and renumbered from 2303.12A to 2303.7A.<br><br>Terminology and acronyms were updated and reworded for clarity and continuity.<br><br>Added language stating Attendant Care Services are only provided to individuals 21 and over when State Plan PCS has been exhausted. Removed language detailing specific tasks allowed under this service.<br>Removed reference to back up plan in #1 as it is mentioned in sections 2303.2B and 2303.2C and is duplicative.<br><br>Removed definition of ADLs and IADLs in #2 as this repetitive. |

| Manual Section | Section Title | Background and Explanation of Policy Changes, Clarifications and Updates |
|---|---|---|
| **2303.7B** | **Provider Responsibilities** | Removed "Attendant Care" from title for consistency.<br><br>Moved and renumbered section from 2303.12B to 2303.7B.<br><br>Terminology and acronyms were updated and reworded for clarity and continuity.<br><br>Removed language stating LRIs may not be paid for providing this service, as LRIs can be paid caregivers.<br><br>Changed language in #1 to "self-directed skilled" to align with MSM Chapter 2600.<br><br>Removed CPR certification requirement and requirement for services to be documented in writing.<br><br>Added #3 indicating providers must receive adequate training specific to persons with physical disabilities and timeframes for training completion.<br><br>Updated and rearranged language stating that services must be prior authorized and documented in an approved EVV system. |
| **2303.7C** | **Recipient Responsibilities** | This section added for consistency.<br><br>Included information regarding recipient's responsibility to utilize an approved EVV system as well as to provide confirmation that services were received via signature/IVR. |
| **2303.8** | **Assisted Living Services** | This section was moved and renumbered from 2303.10 to 2303.8 and subsequent sections renumbered accordingly.<br><br>Summary description of assisted living service added.<br><br>Sentence added to include skilled nursing as permitted by state law. |
| **2303.8A** | **Coverage and Limitations** | This section was moved and renumbered from 2303.10A to 2303.8A.<br><br>Terminology and acronyms were updated and reworded for clarity and continuity. |

| Manual Section | Section Title | Background and Explanation of Policy Changes, Clarifications and Updates |
|---|---|---|
| | | Removed detailed list of services provided in #1 as they are listed in section 2303.8, and it is duplicative.<br><br>Added #5 indicating personalized plan of care is to be developed with the recipient and people of the recipient's choosing. |
| **2303.8B** | **Provider Responsibilities** | Removed "Assisted Living" from title for consistency.<br><br>Terminology and acronyms were updated and reworded for clarity and continuity.<br><br>Several sections regarding licensure requirements were removed and replaced with new verbiage.<br><br>Added #1 indicating AL providers must maintain all licensure standards as outlined by the Bureau of Health Care Quality and Compliance (HCQC).<br><br>Added #2 indicating AL providers must adhere to training requirements outlined by HCQC and ADSD and specific training timeframes.<br><br>Added #3 to include HCBS final rule requirements specific to residential facilities.<br><br>Removed "ADSD" when referencing case managers throughout to encompass both private and public case managers.<br><br>Section #4 regarding Recipient Records requirements was added. |
| **2303.8C** | **Recipient Responsibilities** | This section added for consistency.<br><br>Added language indicating recipient's responsibility to cooperate with providers as well as responsibility to report any problems with delivery of services. |
| **2303.9** | **Chore Services** | This section was renumbered from 2303.5 to 2303.9 and subsequent sections renumbered accordingly.<br><br>Terminology and acronyms were updated and reworded for clarity and continuity.<br><br>Paragraph added detailing when Chore services may be provided and added additional language for clarity. |

| Manual Section | Section Title | Background and Explanation of Policy Changes, Clarifications and Updates |
|---|---|---|
| | | Section moved from 'Coverage and Limitations' section and additional language added for clarity. |
| **2303.9A** | **Coverage and Limitations** | Section renumbered from 2303.5A to 2303.9A.<br><br>Minor deletions and additions made for clarity and in accordance with the description provided in the Background and Explanation section above. |
| **2303.9B** | **Provider Responsibilities** | Removed "Chore Services" from title for consistency. Moved and renumbered this section from 2303.5B to 2303.9B.<br><br>Added #1 indicating providers must obtain training specific to service for persons with physical disabilities and timeframes.<br><br>Added language detailing that services must be prior authorized and documented within an approved EVV system. |
| **2303.9C** | **Recipient Responsibilities** | This section added for consistency.<br><br>Included information regarding recipient's responsibility to utilize an approved EVV system as well as to provide confirmation that services were received via signature. |
| **2303.10** | **Environmental Accessibility Adaptations** | This section moved and renumbered from 2303.7 to 2303.10 and subsequent sections renumbered accordingly.<br><br>Added summary paragraph of environmental accessibility adaptations. |
| **2303.10A** | **Coverage and Limitations** | Section renumbered from 2303.7A to 2303.10A.<br><br>Terminology and acronyms were updated and reworded for clarity and continuity.<br><br>Added #5 indicating rental properties must receive written approval from landlord prior to authorizing the service.<br><br>Removed sentence indicating service must be prior authorized and limited by budget constraints. |

| Manual Section | Section Title | Background and Explanation of Policy Changes, Clarifications and Updates |
|---|---|---|
| **2303.10B** | **Provider Responsibilities** | Removed "Environmental Accessibility Adaptations" from title for consistency.<br><br>Section moved and renumbered from 2303.7B to 2303.10B. |
| **2303.10C** | **Recipient Responsibilities** | This section added for consistency.<br><br>Added additional recipient responsibilities specific to Environmental Adaptations and notification requirements specific to this service. |
| **2303.11** | **Home Delivered Meals** | This section moved but the numbering remains the same.<br><br>The first paragraph under 'Coverage and Limitations' section moved up to this section. |
| **2303.11A** | **Coverage and Limitations** | Section moved but numbering remains the same.<br><br>Terminology and acronyms were updated and reworded for clarity and continuity.<br><br>Added requirement to #4 indicating service is limited to two meals per day.<br><br>Added language to #5 indicating it is the case manager's responsibility to ensure the PA does not exceed two meals per day. |
| **2303.11B** | **Provider Responsibilities** | Section moved but numbering remains the same.<br><br>Removed "Home Delivered Meals" from title for consistency.<br><br>Removed requirement for meal provider to be enrolled with DHCFP and references to NRS.<br><br>Removed requirement for all employees to pass background checks and proof of taxpayer identification number. |
| **2303.11C** | **Recipient Responsibilities** | This section added for consistency.<br><br>Added requirement recipient notification requirements specific to this service. |

| Manual Section | Section Title | Background and Explanation of Policy Changes, Clarifications and Updates |
|---|---|---|
| **2303.12** | **Personal Emergency Response Systems (PERS)** | This section moved and renumbered from 2303.9 to 2303.12 and subsequent sections renumbered accordingly.<br><br>The first paragraph under 'Coverage and Limitations' section moved up to this section and language added to describe the services provided. |
| **2303.12A** | **Coverage and Limitations** | Section moved and renumbered from 2303.9A to 2303.12A.<br><br>Terminology and acronyms were updated and reworded for clarity and continuity.<br><br>Added sentence detailing that the recipient must be capable of using the device appropriately.<br><br>Language in #2 revised to indicate that both installation and ongoing monitoring fee are covered under this service.<br><br>Added #3 regarding the necessity of the service and that it must be documented on the Plan of Care. |
| **2303.12B** | **Provider Responsibilities** | Removed "PERS" from title for consistency.<br><br>Moved and renumbered this section from 2303.9B to 2303.12B.<br><br>Terminology and acronyms were updated and reworded for clarity and continuity.<br><br>Removed information stating provider must provide tax identification number.<br><br>Added monthly monitoring of the PERS device to #2. |
| **2303.12C** | **Recipient Responsibilities** | This section moved and renumbered from 2303.9C to 2303.11C.<br><br>Terminology and acronyms were updated and reworded for clarity and continuity.<br><br>Added language stating recipient cannot dispose of or damage equipment. |

| Manual Section | Section Title | Background and Explanation of Policy Changes, Clarifications and Updates |
|---|---|---|
| | | Removed language stating "when recipient moves out of state" as it is already implied when the recipient has been terminated from the waiver. |
| **2303.13** | **Specialized Medical Equipment and Supplies** | This section was moved and renumbered from 2303.8 to 2303.13 and subsequent sections renumbered accordingly.<br><br>First two paragraphs moved from 'Coverage and Limitations' and second paragraph deleted. |
| **2303.13A** | **Coverage and Limitations** | Section renumbered from 2303.8A to 2303.13A.<br><br>Terminology and acronyms were updated and reworded for clarity and continuity.<br><br>Rearranged section and added updated language regarding service. Removed specific requirements for vehicle adaptations, assistive technology and supplies. |
| **2303.13B** | **Provider Responsibilities** | Section renumbered from 2303.8B to 2303.13B.<br><br>Removed "Specialized Medical Equipment" from title for consistency.<br><br>Terminology and acronyms were updated and reworded for clarity and continuity.<br><br>Removed licensure requirements. |
| **2303.13C** | **Recipient Responsibilities** | This section created for consistency.<br><br>Added recipient notification requirements for this service and that recipient may not request any additional equipment or supplies that were not authorized. |
| **2303.14** | **Electronic Visit Verification (EVV)** | This section was removed from "Waiver Services" and new 2303.14 section created. |
| **2303.15** | **DHCFP LTSS Initial Review** | Created new section outlining specific initial review requirements to be conducted by DHCFP LTSS to align with waiver application.<br><br>Added additional note indicating electronic signatures are acceptable. |

| Manual Section | Section Title | Background and Explanation of Policy Changes, Clarifications and Updates |
|---|---|---|
| **2303.16** | **Waiver Costs** | Added new section indicating waiver expenditures must not exceed the cost for institutional care. |
| **2303.17** | **Quality Assurance Waiver Review** | This section moved and title updated to 'Quality Assurance Waiver Review'.<br><br>Terminology and acronyms were updated and reworded for clarity and continuity.<br>Sections removed and revised to reflect current required review criteria. |
| **2303.18** | **Medicaid Early and Periodic Screening, Diagnostic and Treatments (EPSDT)** | This section was removed from "Waiver Services" and a new 2303.18 section created.<br><br>Terminology and acronyms were updated and reworded for clarity and continuity. |
| **2303.19** | **Provider Enrollment** | This section was moved and renumbered from 2303.13 to 2303.19.<br><br>Terminology and acronyms were updated and reworded for clarity and continuity.<br><br>'Termination' removed from title.<br><br>Added Provider Types and website information for enrollment checklists.<br><br>Removed language regarding termination of providers due to non-compliance. |
| **2303.20** | **Billing Procedures** | This section was renumbered from 2303.15 to 2303.20.<br><br>Terminology and acronyms were updated and reworded for clarity and continuity.<br><br>Added link to access the fiscal agent's website for the 'Provider Billing Guide Manual.'<br>'Coverage and Limitations' and 'Provider Responsibility' sections removed as this information is duplicative and can be found in the Provider Billing Guide Manual. |
| **2303.21** | **Advance Directives** | This section was renumbered from 2303.16 to 2303.21. |

| Manual Section | Section Title | Background and Explanation of Policy Changes, Clarifications and Updates |
|---|---|---|
| | | Additional language was added detailing the case manager's responsibility to provide each recipient with information on Advance Directives. |
| **2304** | **Hearings Requests Due to Adverse Actions** | The title of the section was updated from 'Hearings to 'Hearings Requests Due to Adverse Actions'.<br><br>Added explanation of the hearings process due to adverse action taken on waiver eligibility. |
| **2304.1** | **Suspended Waiver Services** | Section renumbered from 2304.1A to 2304.1.<br><br>Terminology and acronyms were updated and reworded for clarity and continuity.<br><br>The language was updated/reworded for clarity throughout the section. Process for case manager revised. |
| **2304.2** | **Release from Suspended Waiver Services** | This section was renumbered from 2304.1B to 2304.2.<br><br>The language was updated/reworded for clarity throughout the section.<br><br>Removed "(medical, social, or waiver)" from number 2 as it is too specific when discussing POC services and included requirement to record date of resolution to be documented in the case narrative. |
| **2304.3** | **Denial of Waiver Services** | This section was renumbered from 2304.1C to 2304.3.<br><br>Terminology and acronyms were updated and reworded for clarity and continuity.<br><br>Updated title of 2304.3 to "Denial of Waiver Eligibility"<br><br>Updated DHCFP Case Manager or HCBS providers to "Case Manager" throughout section.<br><br>Removed information regarding establishment of POC from number 4 as this will no longer be done during the intake process.<br><br>Added waitlist priority levels 1-4 to #11. |

| Manual Section | Section Title | Background and Explanation of Policy Changes, Clarifications and Updates |
|---|---|---|
| | | Removed #13 indicating a recipient may be denied if an LRI can provide the service, as LRIs are now able to provide some services.<br><br>Added #12 denial reason if there are no enrolled Medicaid providers in the applicant's area.<br><br>Added #13 denial reason if the applicant is in an institution and discharge within 60 days is not anticipated.<br><br>Some information was moved to section for "Reduction or Denial of Direct Waiver Services" as they are denial reasons specific to direct waiver services and not the entirety of the waiver program.<br><br>Added "recipient" to some denial reasons for clarity.<br><br>Added additional denial reason #14 to deny specific waiver services when a recipient does not have a need or ability for the requested waiver service.<br><br>Updated NOD request process. |
| **2304.4** | **Reduction or Denial of Direct Waiver Services** | Section renamed to "Reduction or Denial of Direct Waiver Services" and reasons from Reductions and Denials section combined.<br><br>Terminology and acronyms were updated and reworded for clarity and continuity.<br><br>Added note to clarify when waiver services are reduced to zero it is considered a reduction of services.<br><br>Revised NOD request process. |
| **2304.5** | **Termination of Waiver Program Eligibility** | This section was renumbered from 2304.1D to 2304.5 and renamed "Termination of Waiver Program Eligibility".<br><br>Terminology and acronyms were updated and reworded for clarity and continuity.<br><br>Changed "ADSD" to "Case Manager" throughout to encompass both ADSD and private Case Management. |

| Manual Section | Section Title | Background and Explanation of Policy Changes, Clarifications and Updates |
|---|---|---|
| | | Revised first paragraph to clarify reasons for termination of program eligibility.<br><br>Removed #1 regarding recipient failure to pay patient liability.<br><br>Removed #2 indicating recipient no longer meet physical disability criteria.<br><br>Reworded #3 for clarity and to be consistent with the rest of the MSM, removed specific examples of failure to cooperate in order to cover more termination reasons.<br><br>Updated the language in #7 to encompass more types of fraudulent activities.<br><br>Added #11 death of recipient as a termination.<br><br>Added #12 when a recipient's support system is not adequate to provide a safe environment during the time HCBS waiver services are being provided.<br><br>Added #13 when HCBS Waiver services are not adequate to ensure the health, welfare, and safety of the recipient.<br><br>Added #14 when a recipient fails to cooperate.<br><br>Reworded the last paragraph of this section for clarification that when DWSS receives notification of the recipient's death, DWSS must notify ADSD and DHCFP. |
| **2304.6** | **Reauthorization within 90 days of Waiver Termination** | This section was renumbered from 2304.2 to 2304.6.<br><br>Terminology and acronyms were updated and reworded for clarity and continuity.<br><br>The language was updated/reworded for clarity throughout the section. |
| **2304.6A** | **Coverage and Limitations** | This section added to clarify the process for slot allocation when someone enters a nursing facility, hospital, or is incarcerated. The slot is held for 90 days from the date on the notice of termination. |

| Manual Section | Section Title | Background and Explanation of Policy Changes, Clarifications and Updates |
|---|---|---|
| **2304.6B** | **Provider Responsibilities** | This section added to ensure appropriate action is taken by the case manger when a recipient is reauthorized. |
| **2304.6C** | **Recipient Responsibilities** | This section added to clarify that recipients must cooperate fully with the reauthorization process. |
| **2305** | **Appeals and Hearings** | This section renumbered from 2304.3 to 2305.<br><br>Terminology and acronyms were updated and reworded for clarity and continuity.<br><br>Added language to clarify the need to inform the applicants/recipients of the opportunity to request a Fair Hearing. |

# 2300 INTRODUCTION

The Home and Community Based Services ~~Waiver~~ (HCBS~~HCBW~~) Waiver for Persons with Physical Disabilities (PD Waiver) recognizes many individuals are at risk of being placed in hospitals or ~~n~~Nursing ~~f~~Facilities can be cared for in their homes and communities, preserving their independence and ties to family and friends at an average cost no higher than that of institutional care.

The PD Waiver~~Division of Health Care Financing and Policy's (DHCFP) Home and Community Based Waiver (HCBW) for Persons with Physical Disabilities~~ is an optional ~~program~~service approved by the Centers for Medicare and Medicaid Services (CMS) , which authorizes the Division of Health Care Financing and Policy (DHCFP) the flexibility to design this waiver and select a mix of waiver services based on the identified needs, and is designed to provide~~.~~ ~~The waiver is designed to provide to~~ eligible Medicaid waiver recipients access to both State Plan Services and certain extended Medicaid covered services~~. unique to this waiver. The goal is to allow recipients to live in their own homes or community settings, when appropriate.~~

Nevada acknowledges that persons with disabilities can lead satisfying and productive lives, when they are provided the needed services and supports to do so.
~~Nevada has the flexibility to design this waiver and select the mix of waiver services best meeting the goal to keep people in the community. Such flexibility is predicated on administrative and legislative support, as well as federal approval.~~

~~The Division of Health Care Financing and Policy's (DHCFP) HCBW for Persons with Physical Disabilities originated in 1990. Waiver service provision is based on the identified needs of waiver recipients. Nevada is committed to the goal of integrating persons with disabilities into the community. Nevada understands persons with disabilities are able to lead satisfying and productive lives, and are able to self-direct care when provided needed services and supports to do so.~~

# 2301 AUTHORITY

Section 1915(c) of the Social Security Act (SSA) permits states the option to waive certain Medicaid statutory requirements in order to offer an array of home and community-based services to eligible ~~that an~~ individuals who may require~~s~~ such services in order to remain in their ~~community~~ communities ~~setting~~ and avoid institutionalization. ~~The Division of Health Care Financing and Policy's (DHCFP) Home and Community Based Waiver (HCBW) for Persons with Physical Disabilities is an optional program approved by the Centers for Medicare and Medicaid Services (CMS). The waiver is designed to provide to eligible Medicaid waiver recipients State Plan Services and certain extended Medicaid covered services unique to this waiver. The goal is to allow recipients to live in their own homes or community settings, when appropriate.~~

~~Nevada has the flexibility to design this waiver and select the mix of waiver services best meeting the goal to keep people in the community. Such flexibility is predicated on administrative and legislative support, as well as federal approval.~~

Statutes and Regulations

- Social Security Act (SSA): 1915(c) (HCBS)
- ~~Social Security Act: 1916 (e)~~
- ~~Social Security Act: 1902 (w)~~
- ~~Omnibus Budget Reconciliation Act of 1987~~
- ~~Balanced Budget Act of 1997~~
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- Nevada Revised Statutes (NRS) Chapters, 200 (Crimes Against the Person), 426 (Persons with Disabilities), 427A (Services to Aging Persons and Persons with Disabilities), 422 (Health Care Financing and Policy), 449 (Medical and Other Related Facilities), 616 (Industrial Insurance), 706 (Motor Carriers), and 446 (Food Establishments)
- NRS 449A.114 – Patient Notification of Intent to Transfer
- ~~State Medicaid Manual, Section 44442.3.B.13~~
- ~~State Medicaid Director Letter (SMDL) #01-006 attachment 4-B~~
- ~~Title 42, Code of Federal Regulations (CFR) Part 441, subparts G~~
- ~~42 CFR Part 431, Subpart E~~

- ~~42 CFR Part 431, Subpart B~~
- ~~42 CFR 489, Subpart I~~
- ~~Nevada's Home and Community Based Waiver Agreement for People with Physical Disabilities Nevada Revised Statutes (NRS) Chapter 449, 706, 446, 629, 630, 630a, and 633~~
- ~~Nevada Administrative Code (NAC) Chapters 441A.375 and 706.~~
- 21st Century Cures Act, H.R. 34, Sec. 12006 – 114th Congress
- Section 3715 of The Coronavirus Aid, Relief, and Economic Security (CARES) Act
- 42 CFR 435.540 – Definition of Disability
- 42 CFR 441.301(c)(1) through (c)(5) – Federal Person-Centered Planning and Settings Requirements
- ~~H.R. 6042 – 115th Congress~~

2302 RESERVED

# 2303 POLICY

## 2303.~~2~~1 WAIVER ELIGIBILITY CRITERIA

The PD Waiver ~~DHCFP Home and Community-Based Waiver (HCBW) for Persons with Physical Disabilities~~ waives certain statutory requirements and is offers~~e~~rd ~~Home and Community-Based Services (HCBS)~~ to eligible recipients to assist them to remain in their own homes or community.

Eligibility for the PD Waiver is determined by DHCFP, Aging and Disability Services Division (ADSD), and the Division of Welfare and Supportive Services (DWSS):

A. Each applicant/recipient must meet and maintain a Level of Care (LOC) for admission into a NF and would require imminent placement in a NF (within 30 days or less) if HCBS or other supports are not available.

B. The applicant must have a physical disability as determined by the DHCFP Physician Consultant. For the disability determination process refer to section 2303.1B.

C. Each applicant/recipient must demonstrate a continued need for the services offered under the PD Waiver to prevent placement in a NF or hospital. Utilization of State Plan Services only does not support the qualifications to be covered by the waiver.

D. Each applicant/recipient must require the provision of at least one ongoing waiver service monthly.

E. Each applicant/recipient must have an adequate support system. This support system must be in place to ensure the physical, environmental, and basic care needs of the applicant/recipient are met to provide a safe environment during the hours when HCBS are not being provided.

F. Applicants may be placed from a NF, acute care facility, another HCBS program, or the community.

G. Applicants must meet Medicaid financial eligibility as determined by DWSS initially and for redetermination.

## 2303.~~2~~1A COVERAGE AND LIMITATIONS

1. Services are offered to eligible recipients who, without the waiver services, would require institutional care (provided in a hospital or ~~Nursing Facility (~~NF) within 30 days or less. ~~Recipients on the waiver must meet and maintain waiver eligibility requirements for the waiver.~~

2. Recipients on the waiver must meet and maintain Medicaid's eligibility requirements for the waiver for each month in which waiver services are provided ~~Persons with Physical Disabilities Waiver Eligibility Criteria~~

~~Eligibility for the HCBW for Persons with Physical Disabilities is determined by the combined efforts of the DHCFP and the Division of Welfare and Supportive Services (DWSS).~~

The following determinations must be made for eligibility purposes. Services will not be ~~provided unless the applicant is found eligible in all areas:~~

~~The applicant must be physically disabled.~~

~~Applicants must be certified as physically disabled by the DHCFP Central Office Physician Consultant. Disabling impairments must result from anatomical or physiological abnormalities and must be demonstrable by medically acceptable clinical and laboratory diagnostic techniques and be established by competent medical evidence.~~

~~The DHCFP Physician Consultant and other health care professionals (Disability Determination Team) review medical and non-medical documentation, and determine whether an applicant qualifies as physically disabled.~~

~~b. The applicant must meet and maintain an LOC for admission into an NF within 30 days if HCBW services or other supports were not available.~~

~~1. The applicant must require provision of at least one ongoing waiver service monthly to be determined to need waiver services as documented in the POC.~~

~~c. Applicants must meet financial eligibility for Medicaid as determined by DWSS.~~

3. Services shall not be provided and will not be reimbursed until the applicant/recipient is found eligible for waiver services. Services must be prior authorized.

4. If an applicant is determined to be eligible for more than one HCBS Waiver, the individual cannot receive services under two or more such programs at the same time. The applicant must choose one HCBS Waiver and receive services provided by that program.

5. Recipients of the HCBS Waiver who are enrolled or elect to enroll in a hospice program may be eligible to remain on the waiver if they require waiver services to remain in the community. Close coordination between the hospice agency and the case manager is required to prevent any duplication of services. Refer to Medicaid Services Manual (MSM) Chapter 3200 for additional information on hospice services.

6. Waiver services may not be provided while a recipient is an inpatient of an institution. Section 3715 of the CARES Act may be utilized where HCBS can be provided in an acute care hospital setting as long as those services are:

   a. Identified in an individual's person-centered plan (referred to throughout this chapter as the Plan of Care (POC);

b. Provided to meet needs of the individual that are not met through the provision of hospital services;

c. Not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and

d. Designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual's functional abilities.

~~3~~7. The PD Waiver~~HCBW for Persons with Physical Disabilities~~ is limited by legislative ~~authority~~mandate to a specific number of recipients who can be served through the waiver per year (slots). When ~~all~~no waiver slots or case management providers are ~~full~~available, the ~~DHCFP~~ADSD utilizes a wait list ~~for~~to prioritize applicants who have been pre~~determined~~sumed to be eligible for the waiver.

~~4. Wait List Prioritization~~

~~Nursing facility residents.~~

~~Applicants who have a severe functional disability as defined by Nevada Revised Statute (NRS) 426.721 to 731. Applicants must be dependent or require assistance in the functional areas of eating, bathing and toileting as identified on the LOC screening assessment.~~

~~All other applicants not listed above.~~

~~5~~8. The DHCFP must assure the Center for Medicare and Medicaid Services (CMS) that ~~the~~ DHCFP's total expenditure for home and community-based and other State Plan Medicaid services for all recipients under this waiver will not, in any calendar/waiver year, exceed 100% of the amount that would be incurred by ~~the~~ DHCFP for all these recipients if they had been in an institutional setting in the absence of the waiver. The DHCFP must also document there are safeguards in place to protect the health and welfare of recipients.

~~6. Waiver services may not be provided while a recipient is an inpatient of an institution.~~

~~7. Recipients of the HCBW for Persons with Physical Disabilities who are enrolled or elect to enroll in a hospice program may be eligible to remain on the waiver if they require waiver services to remain in the community. Close case coordination between the hospice agency and the waiver case manager is required to prevent any duplication of services. Refer to Medicaid Services Manual (MSM) Chapter 3200 for additional information on hospice services.~~

~~8. HBCS are not a substitute for natural and informal supports provided by family, friends or other available community resources. Waiver services alone may not address all of the applicant's identified needs.~~

~~9. If an applicant is determined eligible for more than one HCBW program, the individual cannot receive services under two or more such programs at the same time. The applicant/recipient must choose one HCBW program and receive services provided by that program.~~

## 2303.1B DISABILITY DETERMINATION PROCESS

The disability determination process is completed as follows:

1. Request and receive necessary medical evidence from the applicant's acceptable medical sources. Supporting documentation containing sufficient evidentiary information (medical, psychological, and applicable vocational and/or social information) to determine disability.

   Although the ADSD Intake Specialist will assist the applicant in obtaining medical records, each individual is responsible for providing medical evidence showing that they have a physical impairment as well as the severity of the impairment.

2. The applicant must provide acceptable medical evidence demonstrating a physical disability warranting the services needed, which may include one or more of the following:

   a. Primary care office visit notes;

   b. Clinical findings including medical history, diagnosis, physical, and/or discharge summary; and

   c. Treatment and prognosis.

   d. Copies of medical evidence from hospitals, clinics, or other health facilities where an individual has been treated.

3. All medical reports received are considered during the disability determination.

4. Acceptable Medical sources include:

   a. Licensed physicians (medical or osteopathic doctors), Advanced Practice Nurse (APRN), or Physician Assistant (PA/PA-C);

   b. Licensed optometrists, for purposes of establishing visual disorders only;

   c. Licensed podiatrists, for purposes of establishing impairments of the foot, or foot and ankles, depending on whether the state in which the podiatrist practices permit practice of podiatry on the foot only, or the foot and ankle.

5. The DHCFP Physician Consultant will review the application and determine eligibility based on the most recent edition of Disability Evaluation under Social Security Disability Standards within five business days.

6. Once the disability determination decision has been made by DHCFP, the ADSD Intake Unit must be notified of the decision via the HCBS Waiver Eligibility Status Form within ten business days from the date of the request.

7. The DISA screen located in the NOMADS system cannot be accepted as proof of disability.

NOTE: In the event the DHCFP Physician Consultant determines that the applicant does not meet the physical disability criteria, the DHCFP LTSS Unit will issue a NOD to the applicant indicating "The service(s) is/are not substantiated as medically necessary. Contact your Medicaid provider as there may be additional documentation to submit to demonstrate a medical necessity".

## 2303.1C APPLICANT/RECIPIENT RESPONSIBILITIES

1. Applicants/recipients must meet and maintain all criteria to become eligible and remain on the PD Waiver.

2. Applicants and/or their designated representative/LRI must:

   a. Participate and cooperate with the Intake Specialist during the intake process;

   b. Provide medical records within 30 days of request; and

   c. Complete and sign all required waiver forms.

## 2303.~~3~~2 WAIVER SERVICES

~~The~~ DHCFP determines which services will be offered under the HCB~~W~~S Waiver ~~for Persons with Physical Disabilities.~~ Providers and recipients must agree to comply with ~~the~~all waiver requirements for service provision.

## 2303.~~3~~2A COVERAGE AND LIMITATIONS

Under the waiver, the following services are covered if identified in the POC as necessary to remain in the community and avoid institutionalization:

1. Case Management;

2. Homemaker Services;

3. Respite;

4. Attendant Care ~~Chore~~ Services;

5. Assisted Living (AL) Services~~Respite~~;

6. Chore Services;

7. Environmental Accessibility Adaptations (EAA);

8. Home Delivered Meals;

~~Specialized Medical Equipment and Supplies;~~

9. Personal Emergency Response System (PERS);

10. Specialized Medical Equipment and Supplies;

~~Assisted Living Services;~~

~~Home Delivered Meals; and/or~~

~~Attendant Care Services.~~

## 2303.~~3~~2B PROVIDER RESPONSIBILITIES

~~All Providers~~

1. Must obtain and maintain a provider number (Provider Type (PT) 58) through DHCFP's Fiscal Agent

~~Providers are responsible for confirming the recipient's Medicaid eligibility each month prior to rendering service.~~

2. All providers must meet all federal, state, and local statutes, rules and regulations relating to the services being provided.

3. In addition to this chapter, ~~P~~providers must ~~meet and~~also comply with rules and regulations as set forth in ~~all provider requirements as specified in~~ MSM Chapter 100 - Medicaid Program. Failure to comply with any or all stipulations may result in DHCFP's decision to exercise its right to terminate a provider's contract.

4. Provider Termination of Waiver Services

   a. The provider may terminate direct waiver services without notice for any of the following reasons:

      1. The recipient or another person in the household subjects the provider to physical or verbal abuse, sexual harassment and/or exposure to the use of illegal substances, illegal situations, or threats of physical harm;

2. The recipient's Medicaid eligibility is found ineligible for waiver services;

3. The recipient requests termination of services;

4. The place of service is considered unsafe for the provision of waiver services;

5. The recipient refuses services offered in accordance with the approved POC;

6. The recipient is non-cooperative in the establishment or delivery of services, including the refusal to sign required forms;

7. The provider is no longer able to provide services as authorized;

8. The recipient requires a higher level of care that cannot be met by the waiver service;

NOTE: A provider's inability to provide services for a specific recipient does not constitute termination or denial from the HCBS Waiver program. The recipient may choose another provider.

b. Notification Requirements

As appropriate, the provider must notify the recipient and/or designated representative/LRI and agencies of the date when services are to be terminated. The case manager should be notified thirty calendar days prior to the date services will be terminated. The basis for the action and the intervention/resolution(s) attempted must be documented prior to terminating services.

The provider is not required to send a written notice if the recipient has chosen to terminate services.

5. Discontinuation of Direct Waiver Service Provider Agreement

If a provider decides to discontinue providing waiver services for any reason not listed in 2303.2B.4 – Provider Termination of Waiver Services, the provider shall:

a. Provide the recipient with written notice at least 30 calendar days in advance of service discontinuation;

b. Provide the recipient's case manager with a copy of the written notice of intent to discontinue services, including a list of the affected recipients, at least 30 calendar days in advance of service discontinuation; and

c. Continue to provide services through the notice period or until all recipients are receiving services through another provider, whichever occurs sooner.

~~Must enroll and maintain an active HCBW for Persons with Physical Disabilities provider number (Type 58).~~

6. Must understand the authorized service specification on the POC, record keeping responsibilities, and billing procedures for provided waiver services.

~~May only provide services that have been identified in the recipient POC and, if required, have prior authorization.~~

7. Flexibility of Service Delivery

The total weekly authorized hours for Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) may be combined and tailored to meet the needs of the recipient, as long as the plan does not alter medical necessity. The provider and recipient will determine how to use the weekly authorized hours on an ongoing basis; however, any changes that do not increase the total authorized hours can be made within a single week without an additional authorization. Flexibility of services may not take place solely for the convenience of the provider.

8. Must be responsible for any claims submitted or payment received on the recipient's behalf; such claims should be made under penalties of perjury. Any false claims, statement or documents, or concealment of material facts may be prosecuted under applicable federal or state laws.

9. Must understand that payment for services will be based on the level of service or specific tasks identified on the POC.

10. Legally Responsible Individuals (LRI) may be paid to provide activities that family caregivers would not ordinarily perform or are not responsible for performing. Additional dependence on LRIs is above the scope of normal daily activities such as assistance in bathing, dressing, and grooming, toileting, and with specialized medical care needs.

LRIs may furnish attendant care, homemaker, respite, and chore services (refer to the direct waiver service type throughout this chapter for additional limitations). It must be the recipient's choice for the LRI to provide the services, which is achieved through the person-centered Plan of Care (POC) development.

a. LRIs cannot provide State Plan PCS in conjunction with any of the waiver services. State Plan PCS does not allow payment of LRIs.

b. The LRI must be an employee of a provider agency or Intermediary Service Organization (ISO) as a PT 58 with Specialty Code(s) 189, 039, 191, and/or 199.

c. LRIs must utilize an Electronic Visit Verification (EVV) system for check in/check out.

~~Payments will not be made for services provided by a recipient's legally responsible individual.~~

11. All providers may only provide services that have been identified in the POC and have a Prior Authorization (PA), if required.

12. Must have a backup mechanism to provide the recipient with their authorized service hours in the absence of a regular caregiver due to sickness, vacation, or any other unscheduled event. The provider must notify the recipient's case manager if there is a change in the established back-up plan.

13. Sign and date the finalized POC within 60 calendar days from waiver enrollment. If a service has been included on the POC and there is no provider assigned, the signature would not be required until the provider is selected by the individual and would be required by the next face to face visit.

14. Serious Occurrence Report (SOR):

All direct waiver service providers are required to report a SOR within 24 hours of discovery. A written report must be submitted to the assigned case manager within five business days of the incident. All providers are required to maintain a copy of the reported SOR in the recipient's record. It is the provider's responsibility to understand the proper reporting method to the assigned case management provider and participate with any requested follow-up timely.

Reporting of a SOR can be in paper form or electronic format which is accessible to all direct waiver service providers, public and State staff via the DHCFP's public website and the DHCFP Fiscal Agent's website. The process for reporting incidents will vary depending on the case management provider. 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 case management providers, the process for submitting a SOR are as follows:

a. Public (ADSD) Case Management:

Providers must complete the web-based Nevada DHCFP SOR form, available at the Fiscal Agent's website (https://www.medicaid.nv.gov), under Providers - Forms. Upon receipt of the submitted electronic SOR, the ADSD case manager will perform the necessary follow-up.

b. Private Case Management (PCM):

Providers must complete the paper Nevada DHCFP SOR form, available at the Fiscal Agent's website (https://www.medicaid.nv.gov), under Providers - Forms. The completed SOR form must be submitted to the DHCFP LTSS inbox at hcbs@dhcfp.nv.gov. The paper form will be re-routed to the PCM agency who will enter the SOR in their database and perform the necessary follow-up.

Serious occurrences involving either the provider/employee or recipient may include, but are not limited to the following:

1. Suspected physical or verbal abuse;
2. Unplanned hospitalization;
3. Abuse, neglect, exploitation, isolation, abandonment, or unexpected death of the recipient;
4. Injuries requiring medical intervention;
5. Sexual harassment or sexual abuse;
6. Theft;
7. An unsafe living environment;
8. Elopement of a recipient;
9. Medication errors resulting in injury, hospitalization, medical treatment or death;
10. Death of the recipient while enrolled in the HCBS Waiver program;
11. Loss of contact with the recipient for three consecutive scheduled days;
12. Any event which is reported to the Division of Child and Family Services (DCFS) or the appropriate county agency (under 18 years old), Adult Protective Services (APS) (18 years old and above), or law enforcement agencies.

The State of Nevada has established mandatory reporting requirements of suspected incidents of abuse, neglect, isolation, abandonment, and exploitation. APS, DCFS and/or local law enforcement are the receivers of such reports. Suspected abuse must be reported as soon as possible, but no later than 24 hours after the person knows or has reasonable cause to believe that a person has been abused, neglected, isolated, abandoned or exploited. Refer to NRS 200.5091 to 200.50995 "Abuse, neglect, exploitation, abandonment, or isolation of older and vulnerable persons".

15. Criminal Background Checks

DHCFP policy requires all direct waiver service providers and its personnel, including owners, officers, administrators, managers, employees, and consultants to undergo State and Federal Bureau of Investigation (FBI) background checks upon licensure and then at a minimum of every five years thereafter to ensure no convictions of applicable offenses have been incurred. For complete instructions, refer to the Division of Public and Behavioral Health (DPBH) website at https://dpbh.nv.gov.

DHCFP's 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 DHCFP determines is inconsistent with the best interest of recipients. Additional information may be found in MSM Chapter 100 – Medicaid Program.

16. Recipient Records

a. The number of units specified on each recipient's POC, for each specific service will be considered the maximum number of units allowed to be provided by the caregiver and paid by DHCFP's Fiscal Agent, unless the case manager has approved an increase in service due to a temporary condition or circumstance.

b. Cooperate with DHCFP, ADSD and/or State or Federal reviews or inspections of the records.

c. Provider agencies who provide waiver services in the home must comply with the 21st Century CURES Act. Refer to section 2303.14 of this chapter for detailed information.

17. Adhere to Health Insurance Portability and Accountability Act (HIPAA) requirements. Refer to MSM Chapter 100 for information on HIPAA, privacy and confidentiality of recipient records, and other protected health information.

18. Obtain and maintain a business license as required by city, county, or state government, if applicable.

19. Providers must obtain and maintain required Health Care Quality and Compliance (HCQC) licensure, if required.

20. Qualifications and Training:

a. All service providers must arrange training for employees who have direct contact with recipients of the PD Waiver and must have service specific training prior to performing a waiver service. Training at a minimum must include, but is not limited to:

1. Policies, procedures, and expectations of the agency relevant to the provider, including recipient and provider rights and responsibilities;

2. Record keeping and reporting including daily records and SORs;

3. Information about the specific needs and goals of the recipients to be served;

4. Interpersonal and communication skills and appropriate attitudes for working effectively with recipients to include; understanding care goals; respecting recipient rights and needs; respect for age, cultural and ethnic differences; tolerant of the varied lifestyles of the people served, recognizing family relationships; confidentiality; and abuse. Neglect, and exploitation, including signs, symptoms, and prevention; respecting personal property; ethics in dealing with the recipient, family, and other providers; handling conflict and complaints; and other topics as relevant; and

5. Paid and unpaid staff must receive one hour of training related to the rights of the rights of the individual receiving services and individual experience as outlined in the HCBS Final Regulation.

~~Provider Agencies~~

~~Agencies employing providers of service for the waiver program must arrange training in at least the following subjects:~~

~~policies, procedures and expectations of the contract agency relevant to the provider, including recipient's and provider's rights and responsibilities;~~

~~procedures for billing and payment, if applicable;~~

~~record keeping and reporting;~~

~~information about the specific disabilities of the persons to be served and, more generally, about the types of disabilities among the populations the provider will serve, including physical and psychological aspects and implications, types of resulting functional deficits, and service needs;~~

~~recognizing and appropriately responding to medical and safety emergencies;~~

~~working effectively with recipients including: understanding recipient direction and the independent living philosophy; respecting consumer rights and needs; respect for age, cultural and ethnic differences; recognizing family relationships; confidentiality; respecting personal property; active~~

~~listening and responding; emotional support and empathy; ethics in dealing with the recipient, legally responsible individual and other providers; handling conflict and complaints; dealing with death and dying; and other topics as relevant.~~

~~Exemptions from Training~~

~~The agency may exempt a prospective service provider from those parts of the required training where the agency verifies the person possesses adequate knowledge or experience, or where the provider's duties will not require the particular skills.~~

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

~~Recipients Providing Training~~

~~Where a recipient desires to provide training and the recipient is able to state and convey his/her needs to a caregiver, the agency will allow the recipient to do so.~~

~~Any such decision shall be agreed to by the recipient and documented in the case record as to what training the recipient is to provide.~~

~~Where the recipient or other private third-party functions as the employer such individual may exercise the exemption from training authority identified above.~~

~~Completion and Documentation of Training~~

~~The provider shall complete required training within six months of beginning employment. Training as documented in the MSM 2303.2 B.2.b., except for the service areas requiring completion of Cardiopulmonary Resuscitation (CPR) (as listed in the specific service area sections of this chapter) which should be completed in a six month timeframe, and 2303.2 B.2.b.(6-8), which must be completed prior to service provision.~~

~~Each provider agency must have a file for each recipient. In the recipient's file, the agency must maintain the daily records. Periodically, the DHCFP Central Office staff may request this documentation to compare to billings~~

~~submitted. These records must be maintained by the provider for at least six years after the date the claim is paid.~~

~~Flexibility of service delivery which does not alter medical necessity may occur within a single week period without an additional authorization. Reference Section 2303B.e.~~

## ~~2303.1 ADMINISTRATIVE CASE MANAGEMENT ACTIVITIES~~

~~Administrative case management occurs prior to an applicant being determined eligible for a waiver and during a re-evaluation or reassessment of eligibility. Administrative case management may only be provided by qualified staff.~~

## ~~2303.1A COVERAGE AND LIMITATIONS~~

~~Administrative case management activities include:~~

~~1. Intake referral;~~

~~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. Preliminary and ongoing assessments, evaluations and completion of forms required for service eligibility:~~

~~a. The Plan of Care (POC) identifies the waiver services as well as other ongoing community support services that the recipient needs in order to live successfully in the community. The POC must reflect the recipient's service needs and include both waiver and non-waiver services in place at the time of POC completion, along with informal supports that are necessary to address those needs.~~

~~b. The recipient's Level of Care (LOC), functional status and needs addressed by the POC must be reassessed annually or more often as needed. The recipient must also be reassessed when there is a significant change in his/her condition which influences eligibility. The reassessment is to be conducted during a face-to-face visit.~~

~~c. If services documented on a POC are approved by the recipient and the case manager and the recipient signature cannot be obtained due to extenuating circumstances, services can commence with verbal approval from the recipient. Case managers must document the recipient's verbal approval in the case notes and obtain the recipient signature on the POC as soon as possible.~~

~~4. Issuance of a Notice of Decision (NOD) when a waiver application is denied;~~

~~5. Coordination of care and services to collaborate in discharge planning to transition applicants from facilities;~~

~~6. Documentation for case files prior to applicant's eligibility;~~
~~7. Case closure activities upon termination of service eligibility;~~

~~8. Outreach activities to educate recipients or potential recipients on how to enter into care through a Medicaid Program;~~

~~9. Communication of the POC to all affected providers;~~

~~10. If attendant care services are medically necessary, the case manager is then responsible for implementation of services and continued authorization of services;~~

~~11. Completion of prior authorization form in the Medicaid Management Information System (MMIS).~~

~~12. Travel time to and from scheduled home visits.~~

## ~~2303.1B ADMINISTRATIVE CASE MANAGEMENT PROVIDER RESPONSIBILITIES~~

~~Employees of the Division of Health Care Financing and Policy (DHCFP), Health Care Coordinator (HCC) I, II, or III are qualified Medicaid case managers for the Waiver. Professional or medical licensure recognized by a Nevada Professional State Board, such as social worker, registered nurse, occupational therapist or physical therapist is required. A Licensed Practical Nurse (LPN) may complete back up case management, operating under a previously developed LOC and POC under the supervision of the primary case manager.~~

## ~~2303.1C RECIPIENT RESPONSIBILITIES~~

~~1. Participate in the waiver assessment and reassessment process.~~

~~2. Participate in monthly contacts and home visits with the case manager.~~

~~3. Together with the waiver case manager, develop and/or review the POC.~~

~~4. If services documented on the POC are approved by the recipient and the case manager and the recipient signature cannot be obtained due to extenuating circumstances, services can commence or continue with verbal approval from the recipient. Case managers must document the recipient's verbal approval in the case notes and obtain the recipient signature on the POC as soon as possible.~~

## ~~2303.2 ELIGIBILITY CRITERIA~~

~~The DHCFP Home and Community-Based Waiver (HCBW) for Persons with Physical Disabilities~~

~~waives certain statutory requirements and offers Home and Community-Based Services (HCBS) to eligible recipients to assist them to remain in the community.~~

~~2303.2A COVERAGE AND LIMITATIONS~~

~~1. Services are offered to eligible recipients who, without the waiver services, would require institutional care provided in a hospital or Nursing Facility (NF). Recipients on the waiver must meet and maintain waiver eligibility requirements for the waiver.~~

~~2.1. Persons with Physical Disabilities Waiver Eligibility Criteria~~

~~Eligibility for the HCBW for Persons with Physical Disabilities is determined by the combined efforts of the DHCFP and the Division of Welfare and Supportive Services (DWSS).~~

~~The following determinations must be made for eligibility purposes. Services will not be provided unless the applicant is found eligible in all areas:~~

~~a. The applicant must be physically disabled.~~

~~1. Applicants must be certified as physically disabled by the DHCFP Central Office Physician Consultant. Disabling impairments must result from anatomical or physiological abnormalities and must be demonstrable by medically acceptable clinical and laboratory diagnostic techniques and be established by competent medical evidence.~~

~~2.1. The DHCFP Physician Consultant and other health care professionals (Disability Determination Team) review medical and non-medical documentation, and determine whether an applicant qualifies as physically disabled.~~

~~b. The applicant must meet and maintain an LOC for admission into an NF within 30 days if HCBW services or other supports were not available.~~

~~1. The applicant must require provision of at least one ongoing waiver service monthly to be determined to need waiver services as documented in the POC.~~

~~c. Applicants must meet financial eligibility for Medicaid as determined by DWSS.~~

~~3. The HCBW for Persons with Physical Disabilities is limited, by legislative authority to a specific number of recipients who can be served through the waiver per year (slots). When all waiver slots are full, the DHCFP utilizes a wait list for applicants who have been pre-determined to be eligible for the waiver.~~

~~4. Wait List Prioritization~~

~~a. Nursing facility residents.~~

~~b.a. Applicants who have a severe functional disability as defined by Nevada Revised Statute (NRS) 426.721 to 731. Applicants must be dependent or require assistance in the functional areas of eating, bathing and toileting as identified on the LOC screening assessment.~~

~~c.a. All other applicants not listed above.~~

~~5. The DHCFP must assure the Center for Medicare and Medicaid Services (CMS) that the DHCFP's total expenditure for home and community-based and other State Plan Medicaid services for all recipients under this waiver will not, in any calendar/waiver year, exceed 100% of the amount that would be incurred by the DHCFP for all these recipients if they had been in an institutional setting in the absence of the waiver. The DHCFP must also document there are safeguards in place to protect the health and welfare of recipients.~~

~~6. Waiver services may not be provided while a recipient is an inpatient of an institution.~~

~~7. Recipients of the HCBW for Persons with Physical Disabilities who are enrolled or elect to enroll in a hospice program may be eligible to remain on the waiver if they require waiver services to remain in the community. Close case coordination between the hospice agency and the waiver case manager is required to prevent any duplication of services. Refer to Medicaid Services Manual (MSM) Chapter 3200 for additional information on hospice services.~~

~~8. HBCS are not a substitute for natural and informal supports provided by family, friends or other available community resources. Waiver services alone may not address all of the applicant's identified needs.~~

~~9. If an applicant is determined eligible for more than one HCBW program, the individual cannot receive services under two or more such programs at the same time. The applicant/recipient must choose one HCBW program and receive services provided by that program.~~

## ~~2303.2B MEDICAID EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)~~

~~The children made eligible for Medicaid through their enrollment in the HCBW for Persons with Physical Disabilities receive all medically necessary Medicaid covered services available under EPSDT. A child's enrollment in the waiver will not be used to deny, delay, or limit access to medically necessary service(s) required to be available to Medicaid-eligible children under federal EPSDT rules. The waiver service package is a supplement to EPSDT services.~~

## ~~2303.3 WAIVER SERVICES~~

~~The DHCFP determines which services will be offered under the HCBW for Persons with Physical Disabilities. Providers and recipients must agree to comply with the requirements for service provision.~~

## ~~2303.3A COVERAGE AND LIMITATIONS~~

~~Under the waiver, the following services are covered if identified in the POC as necessary to avoid institutionalization:~~

~~1.9.Case Management;~~

~~2.9.Homemaker Services;~~

~~3.9.Chore Services;~~

~~4.9.Respite;~~

~~5.9.Environmental Accessibility Adaptations;~~

~~6.9.Specialized Medical Equipment and Supplies;~~

~~7.9.Personal Emergency Response System (PERS);~~

~~8.9.Assisted Living Services;~~

~~9. Home Delivered Meals; and/or~~

~~10.9. Attendant Care Services.~~

## ~~2303.3B PROVIDER RESPONSIBILITIES~~

~~1. All Providers~~

~~a. Providers are responsible for confirming the recipient's Medicaid eligibility each month prior to rendering service.~~

~~b.a. Providers must meet and comply with all provider requirements as specified in MSM Chapter 100.~~

~~c.a. Must enroll and maintain an active HCBW for Persons with Physical Disabilities provider number (Type 58).~~

~~d.a. May only provide services that have been identified in the recipient POC and, if required, have prior authorization.~~

~~e.a. The total weekly authorized hours for Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) may be combined and tailored to meet the needs of the recipient, as long as the plan does not alter medical necessity. The provider and recipient will determine how to use the weekly authorized hours on an ongoing basis; however, any changes that do not increase the total authorized hours can be made within a single week without an additional authorization. Flexibility of services may not take place solely for the convenience of the provider.~~

~~f.a. Payments will not be made for services provided by a recipient's legally responsible individual.~~

~~2. Provider Agencies~~

~~a. Agencies employing providers of service for the waiver program must arrange training in at least the following subjects:~~

~~1. policies, procedures and expectations of the contract agency relevant to the provider, including recipient's and provider's rights and responsibilities;~~

~~2.1. procedures for billing and payment, if applicable;~~

~~3.1. record keeping and reporting;~~

~~4.1. information about the specific disabilities of the persons to be served and, more generally, about the types of disabilities among the populations the provider will serve, including physical and psychological aspects and implications, types of resulting functional deficits, and service needs;~~

~~5.1. recognizing and appropriately responding to medical and safety emergencies;~~

~~6.1. working effectively with recipients including: understanding recipient direction and the independent living philosophy; respecting consumer rights and needs; respect for age, cultural and ethnic differences; recognizing family relationships; confidentiality; respecting personal property; active listening and responding; emotional support and empathy; ethics in dealing with the recipient, legally responsible individual and other providers; handling conflict and complaints; dealing with death and dying; and other topics as relevant.~~

~~7.1. Exemptions from Training~~

~~a. The agency may exempt a prospective service provider from those parts of the required training where the agency verifies the person possesses adequate knowledge or experience, or where the provider's duties will not require the particular skills.~~

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

~~8.1. Recipients Providing Training~~

~~a. Where a recipient desires to provide training and the recipient is able to state and convey his/her needs to a caregiver, the agency will allow the recipient to do so.~~

~~b.a. Any such decision shall be agreed to by the recipient and documented in the case record as to what training the recipient is to provide.~~

~~c.a. Where the recipient or other private third party functions as the employer such individual may exercise the exemption from training authority identified above.~~

~~9.1. Completion and Documentation of Training~~

~~The provider shall complete required training within six months of beginning employment. Training as documented in the MSM 2303.2 B.2.b., except for the service areas requiring completion of Cardiopulmonary Resuscitation (CPR) (as listed in the specific service area sections of this chapter) which should be completed in a six month timeframe, and 2303.2 B.2.b.(6-8), which must be completed prior to service provision.~~

~~10.1. Each provider agency must have a file for each recipient. In the recipient's file, the agency must maintain the daily records. Periodically, the DHCFP Central Office staff may request this documentation to compare to billings submitted. These records must be maintained by the provider for at least six years after the date the claim is paid.~~

~~11.1. Flexibility of service delivery which does not alter medical necessity may occur within a single week period without an additional authorization. Reference Section 2303B.e.~~

~~c. All waiver providers must provide the local DHCFP District Office Waiver Case Manager with written notification of serious occurrences involving the recipient within 24 hours of discovery.~~

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

~~1. Unplanned hospital or Emergency Room (ER) visit;~~

~~2. Injury or fall requiring medical intervention;~~

~~3. Alleged physical, verbal, sexual abuse or sexual harassment;~~

~~4. Alleged theft or exploitation;~~

~~5. Medication error;~~

~~6. Death of the recipient or significant care giver; or~~

~~7. Loss of contact with the recipient for three consecutive scheduled days.~~

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

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

~~Child Abuse - Refer to NRS 432B regarding child abuse or neglect.~~

~~Elder Abuse - Refer to NRS 200.5091 to 200.50995 regarding elder abuse or neglect.~~

~~Other Age Groups - For all other individuals or vulnerable persons (NRS 200.5091 to 200.50995) defined as "a person 18 years of age or older who:~~

~~suffers from a condition of physical or mental incapacitation because of a developmental disability, organic brain damage or mental illness; or~~

~~has one or more physical or mental limitations that restrict the ability of the person to perform the normal ADLs," contact local law enforcement agencies.~~

~~e. Before initial employment, an employee must have a:~~

~~Physical examination or certification from a licensed physician that the person is in a state of good health, is free from active Tuberculosis (TB) and any other communicable disease in a contagious stage; and~~

~~TB screening test within the preceding 12 months, including persons with a history of Bacillus Calmett-Guerin (BCG) vaccination.~~

~~If the employee has only completed the first step of a 2-step Mantoux Tuberculin skin test within the preceding 12 months, then the second step of the 2-step Mantoux Tuberculin skin test or other single-step TB screening test must be administered. A single annual TB screening test must be administered thereafter. An employee who tests positive to either of the 2-step Mantoux Tuberculin skin tests must obtain a chest x-ray and medical evaluation for active TB.~~

~~An employee with a documented history of a positive TB screening test is exempt from skin testing and chest x-rays unless he/she develops symptoms suggestive of active TB.~~

~~An employee who is exempt from skin testing and chest x-rays must submit to an annual screening for signs and symptoms of active disease which must be completed prior to the one-year anniversary of the last screening. Documentation of the annual screening and the results must be maintained in the employee's file. The annual screening must address each of the following areas of concern and must be administered and/or reviewed by a qualified health care professional.~~

~~Has had a cough for more than three weeks;~~

~~Has a cough which is productive;~~

~~Has blood in his/her sputum;~~

~~Has a fever which is not associated with a cold, flu or other apparent illness;~~

~~Is experiencing night sweats;~~

~~Is experiencing unexplained weight loss; or~~

~~Has been in close contact with a person who has active TB.~~

~~Annual screening for signs and symptoms of active disease must be completed prior to the one year anniversary of the last screening. Documentation of the annual screening and the results must be maintained in the employee's file.~~

~~Documentation of TB testing must be issued by a medical facility or licensed medical professional qualified to administer the test, signed by the physician or his/her designee, stating the date of the test, the date the test was read, and the~~

~~results, and maintained in the employee's file. Any lapse in the required timelines above results in non-compliance with this Section.~~

~~In addition, providers must also comply with the TB requirements outlined in Nevada Administrative Code (NAC) 441A.375 and 441A.380.~~

~~f. All waiver providers, including owners, officers, administrators, managers, employees (who have direct contact with recipients) and consultants must undergo State and Federal Bureau of Investigation (FBI) background checks upon enrollment as a provider and then at a minimum of every five years thereafter to ensure no convictions of applicable offenses have been incurred and the safety of recipients is not compromised.~~

~~The DHCFP policy requires all waiver providers have State and Federal criminal history background checks completed. 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.~~

~~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 Health website at: http://health.nv.gov/HCQC_CriminalHistory_Fingerprints.htm.~~

~~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):~~

~~murder, voluntary manslaughter or mayhem;~~

~~assault with intent to kill or to commit sexual assault or mayhem;~~

~~sexual assault, statutory sexual seduction, incest, lewdness, indecent exposure or any other sexually related crime;~~
~~abuse or neglect of a child or contributory delinquency;~~

~~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;~~

~~a violation of any provision of NRS 200.700 through 200.760;~~

~~criminal neglect of a patient as defined in NRS 200.495;~~

~~any offense involving fraud, theft, embezzlement, burglary, robbery, fraudulent conversion or misappropriation of property;~~

~~any felony involving the use of a firearm or other deadly weapon;~~

~~abuse, neglect, exploitation or isolation of older persons;~~

~~kidnapping, false imprisonment or involuntary servitude;~~

~~any offense involving assault or battery, domestic or otherwise;~~

~~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;~~

~~conduct or practice detrimental to the health or safety of the occupants or employees of the facility or agency; or~~

~~any other offense that may be inconsistent with the best interests of all recipients.~~

~~g. Providers are required to initiate diligent and effective follow up for results of background checks within 90 days of submission of prints and continue until results are received. 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.~~

2303~~2~~2.3C RECIPIENT RESPONSIBILITIES

The recipient, or if applicable, ~~or~~ the recipient's ~~authorized~~designated representative/LRI will:

1. ~~n~~Notify the provider(s) and ~~c~~Case ~~m~~Manager of any change in Medicaid eligibility upon discovery~~.~~;

2. Notify the direct service provider(s) and DWSS of current insurance information, including the name of the insurance coverage, such as Medicare;

3. ~~n~~Notify the direct service provider(s) and ~~c~~Case ~~m~~Manager of changes in medical status, support systems, service needs, address, ~~and~~or location changes, and/or ~~of~~any changes ~~of~~in status of designated representative/LRI~~legally responsible individual(s) or authorized representative~~;~~.~~

4. ~~t~~Treat all providers and staff members ~~and providers~~ appropriately Provide a safe, non-threatening and healthy environment for caregiver(s) and the case manager(s);.

5. ~~if capable, s~~Sign and date the provider(s) ~~daily~~ record(s) as appropriate to verify services were provided. If the recipient is unable to provide a signature due to cognitive and/or physical limitations, this will be clearly documented on the Statement of Choice (SOC) and/or POC, as appropriate;

6. ~~n~~Notify the provider and case manager when scheduled visits cannot be kept or services are no longer required~~.~~;

7. ~~n~~Notify the provider agency or case manager of any missed ~~visits~~appointments by the provider agency staff;~~.~~

8. ~~n~~Notify the provider agency or case manager of any unusual occurrences, complaints regarding delivery of services, specific staff, or to request a change in caregiver or provider agency;~~.~~

9. ~~f~~Furnish the provider agency with a copy of their Advance Directives if appropriate~~.~~;

10. Work with the provider agency to establish a back-up plan in case ~~a~~the caregiver ~~waiver attendant~~ is unable to work at the scheduled time, and report to the case manager if there is a change to the established back-up plan~~.~~;

11. ~~n~~Not request a provider to work more than the hours authorized in the ~~service plan~~POC~~.~~;

12. Understand that ~~not request~~ a provider ~~to~~may not work or clean for a ~~non~~-recipient's family, ~~or~~ household members, or other persons living in the home with the recipient~~.~~;

13. ~~n~~Not request a provider to perform services not included in the ~~care plan~~POC~~.~~;

14. ~~c~~Contact the ~~c~~Case ~~m~~Manager to request a change of provider agency~~.~~;

15. Complete, sign, date, and submit all required forms within ten calendar days~~.~~;

16. Understand that at least one annual face-to-face visit is required;

17. Be physically available for authorized waiver services, face-to-face visits, and assessments;

~~meet and maintain all criteria to be eligible, and to remain on the HCBW for Persons with Physical Disabilities.~~

~~may have to pay patient liability. Failure to pay is grounds for termination from the waiver.~~

18. ~~a~~Agree to utilize an approved Electronic Visit Verification (EVV) system for the waiver personal care like services being received from the provider agency; and~~.~~

19. ~~c~~Confirm services were provided by electronically signing or initialing, as appropriate per ~~service plan~~POC, the EVV record that reflects the service rendered. If Interactive Voice Response (IVR) is utilized, a vocal confirmation is required.

20. Actively participate in the development of the POC which allows the recipient to make informed choices.

~~b. ELECTRONIC VISIT VERIFICATION (EVV):~~

~~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 program. 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.~~

~~1. 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.

2. DATA AGGREGATOR OPTION:

a. All Personal Care Agencies that utilize a different EVV system (as approved by the DHCFP) must comply with all documentation requirements of this chapter and must utilize the data aggregator to report encounter or claim data.

1. 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.

2. At a minimum, data uploads must be completed monthly into data aggregator.

c. All waiver providers must provide the local DHCFP District Office Waiver Case Manager with written notification of serious occurrences involving the recipient within 24 hours of discovery.

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

1. Unplanned hospital or Emergency Room (ER) visit;

2. Injury or fall requiring medical intervention;

3. Alleged physical, verbal, sexual abuse or sexual harassment;

~~4. Alleged theft or exploitation;~~

~~5. Medication error;~~

~~6. Death of the recipient or significant care giver; or~~

~~7. Loss of contact with the recipient for three consecutive scheduled days.~~

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

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

~~1. Child Abuse - Refer to NRS 432B regarding child abuse or neglect.~~

~~2.1. Elder Abuse - Refer to NRS 200.5091 to 200.50995 regarding elder abuse or neglect.~~

~~3.1. Other Age Groups - For all other individuals or vulnerable persons (NRS 200.5091 to 200.50995) defined as "a person 18 years of age or older who:~~

~~a. suffers from a condition of physical or mental incapacitation because of a developmental disability, organic brain damage or mental illness; or~~

~~b.a. has one or more physical or mental limitations that restrict the ability of the person to perform the normal ADLs," contact local law enforcement agencies.~~

~~e. Before initial employment, an employee must have a:~~

~~1. Physical examination or certification from a licensed physician that the person is in a state of good health, is free from active Tuberculosis (TB) and any other communicable disease in a contagious stage; and~~

~~2.1. TB screening test within the preceding 12 months, including persons with a history of Bacillus Calmett-Guerin (BCG) vaccination.~~

~~If the employee has only completed the first step of a 2-step Mantoux Tuberculin skin test within the preceding 12 months, then the second step of the 2-step Mantoux Tuberculin skin test or other single-step TB screening test must be administered. A single annual TB screening test must be administered thereafter. An employee who tests positive to either of the 2-step Mantoux Tuberculin skin tests must obtain a chest x-ray and medical evaluation for active TB.~~

~~An employee with a documented history of a positive TB screening test is exempt from skin testing and chest x-rays unless he/she develops symptoms suggestive of active TB.~~

~~An employee who is exempt from skin testing and chest x-rays must submit to an annual screening for signs and symptoms of active disease which must be completed prior to the one-year anniversary of the last screening. Documentation of the annual screening and the results must be maintained in the employee's file. The annual screening must address each of the following areas of concern and must be administered and/or reviewed by a qualified health care professional.~~
~~1. Has had a cough for more than three weeks;~~

~~2.1. Has a cough which is productive;~~

~~3.1. Has blood in his/her sputum;~~

~~4.1. Has a fever which is not associated with a cold, flu or other apparent illness;~~

~~5.1. Is experiencing night sweats;~~

~~6.1. Is experiencing unexplained weight loss; or~~

~~7.1. Has been in close contact with a person who has active TB.~~

~~Annual screening for signs and symptoms of active disease must be completed prior to the one year anniversary of the last screening. Documentation of the annual screening and the results must be maintained in the employee's file.~~

~~Documentation of TB testing must be issued by a medical facility or licensed medical professional qualified to administer the test, signed by the physician or his/her designee, stating the date of the test, the date the test was read, and the results, and maintained in the employee's file. Any lapse in the required timelines above results in non-compliance with this Section.~~

~~In addition, providers must also comply with the TB requirements outlined in Nevada Administrative Code (NAC) 441A.375 and 441A.380.~~

~~f. All waiver providers, including owners, officers, administrators, managers, employees (who have direct contact with recipients) and consultants must undergo State and Federal Bureau of Investigation (FBI) background checks upon enrollment as a provider and then at a minimum of every five years thereafter to ensure no convictions of applicable offenses have been incurred and the safety of recipients is not compromised.~~

~~1. The DHCFP policy requires all waiver providers have State and Federal criminal history background checks completed. 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.~~

~~2.1. 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 Health website at: http://health.nv.gov/HCQC_CriminalHistory_Fingerprints.htm.~~

~~3.1. 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;~~

~~2.1. assault with intent to kill or to commit sexual assault or mayhem;~~

~~3.1. sexual assault, statutory sexual seduction, incest, lewdness, indecent exposure or any other sexually related crime;~~

~~4.1. abuse or neglect of a child or contributory delinquency;~~

~~5.1. 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;~~

~~6.1. a violation of any provision of NRS 200.700 through 200.760;~~

~~7.1. criminal neglect of a patient as defined in NRS 200.495;~~

~~8.1. any offense involving fraud, theft, embezzlement, burglary, robbery, fraudulent conversion or misappropriation of property;~~

~~9.1. any felony involving the use of a firearm or other deadly weapon;~~

~~10.1. abuse, neglect, exploitation or isolation of older persons;~~

~~11.1. kidnapping, false imprisonment or involuntary servitude;~~

~~12.1. any offense involving assault or battery, domestic or otherwise;~~

~~13.1. 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;~~

~~14.1. conduct or practice detrimental to the health or safety of the occupants or employees of the facility or agency; or~~

~~15.1. any other offense that may be inconsistent with the best interests of all recipients.~~

~~g. Providers are required to initiate diligent and effective follow up for results of background checks within 90 days of submission of prints and continue until results are received. 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.~~

## ~~2303.3C RECIPIENT RESPONSIBILITIES~~

~~The recipient or the recipient's authorized representative will:~~

~~1. notify the provider(s) and case manager of a change in Medicaid eligibility.~~

~~2.1. notify the provider(s) and case manager of changes in medical status, service needs, address, and location, or of changes of status of legally responsible individual(s) or authorized representative.~~

~~3.1. treat all staff and providers appropriately.~~

~~4.1. if capable, sign the provider daily record to verify services were provided.~~

~~5.1. notify the provider when scheduled visits cannot be kept or services are no longer required.~~

~~6.1. notify the provider agency of missed visits by provider agency staff.~~

~~7.1. notify the provider agency of unusual occurrences, complaints regarding delivery of services, specific staff, or to request a change in caregiver.~~

~~8.1. furnish the provider agency with a copy of their Advance Directives.~~

~~9.1. establish a back-up plan in case a waiver attendant is unable to work at the scheduled time.~~

~~10.1. not request a provider to work more than the hours authorized in the service plan.~~

~~11.1. not request a provider to work or clean for a non-recipient, family, or household members.~~

~~12.1. not request a provider to perform services not included in the care plan.~~

~~13.1. contact the case manager to request a change of provider.~~
~~14.1. sign all required forms.~~

~~15. meet and maintain all criteria to be eligible, and to remain on the HCBW for Persons with Physical Disabilities.~~

~~16.15. may have to pay patient liability. Failure to pay is grounds for termination from the waiver.~~

~~17.15. agree to utilize an approved EVV system for the waiver services being received from the provider agency.~~

~~18.15. confirm services were provided by electronically signing or initialing, as appropriate per service plan, the EVV record that reflects the service rendered. If IVR is utilized, a vocal confirmation is required.~~

## 2303.3 INTAKE ACTIVITIES

Intake activities are a function of the ADSD Operations Agency and occur prior to an applicant being determined eligible for a waiver.

## 2303.3A COVERAGE AND LIMITATIONS

1. Intake Referral Process

ADSD Operations Agency has developed policies and procedures to ensure fair and adequate access to services covered under the PD Waiver. All new referrals will be submitted to the ADSD Intake Unit for evaluation and processing.

a. Referral/Application

1. A referral for the PD waiver may be initiated by completing an ADSD Program Application and submitting it to the appropriate ADSD District Office by mail, email, fax, or in person by the applicant and/or designated representative/LRI.

   NOTE: An inquiry for the PD Waiver may be made via phone, mail, email, fax or in person through any ADSD District Office. An inquiry is not considered an application for the PD Waiver and does not initiate the application process.

2. When an application is received and assigned, the ADSD Intake Specialist will make phone/email/verbal contact with the applicant and/or designated representative/LRI within 15 working days of receipt of the application.

   During the initial phone/email/verbal contact, the applicant is advised they have 30 calendar days to gather medical records demonstrating their physical disability in order to continue the application process.

3. Once medical records have been received, a face-to-face visit is scheduled by the ADSD Intake Specialist within 45 days of the application date to assess the LOC and complete all necessary intake forms. The LOC assessment will determine the applicant's eligibility for waiver services and placement on the waitlist, if appropriate.

4. If the applicant is determined to meet NF LOC criteria, ADSD will provide medical records and LOC determination to DHCFP LTSS for the disability determination. Refer to MSM 2303.1B for more information on the disability determination process.

5. If the applicant does not meet the waiver requirements, the applicant must be sent a Denial NOD issued by the DHCFP LTSS Unit, and verbally informed of the right to continue the Medicaid application process through DWSS. The applicant will also be referred to other agencies and community resources for services and/or assistance.

2. Placement on the Wait List when No Waiver Slot is Available

   a. If no Waiver slot is available, and the ADSD Intake Specialist has determined the applicant meets NF LOC, and has a Waiver service need, the applicant will be placed on the wait list according to priority and referral date.

      Wait List Priority:

Level 1 Applicants previously in a hospital or NF and who have been discharged to the community within six months and have a significant change in support systems and are in a crisis situation;

Level 2: Applicants who have a significant change in support systems and/or are in a crisis situation and require at least maximum assistance in a combination of four or more of the following ADLs: eating, bathing, toileting, transfers, and mobility;

Level 3: Applicants who have a significant change in support system and/or are in a crisis situation and require assistance with a combination of five or more of the following ADLs as identified on the LOC screening: medication administration, special needs, bed mobility, transferring, dressing, eating and feeding, hygiene, bathing, toileting, and locomotion;

Level 4: Applicants who do not meet the criteria for priority levels 1-3.

b. Applicants may be considered for an adjusted placement on the waitlist based on a significant change of condition/circumstances.

c. A denial NOD is sent to applicants who are placed on the waitlist indicating "no slot available and applicant's priority level on the waitlist".

3. Waiver Slot Allocation

Once a slot for the waiver is available, the applicant will be processed for the waiver.

The procedure used for processing an applicant is as follows:

a. The ADSD Intake Specialist will work with the applicant to complete any paperwork that was not collected during the initial assessment.

b. The applicant/designated representative/LRI must understand and agree that personal information may be shared with providers of services and others, as specified on the form.

c. The applicant will be given the right to choose waiver services in lieu of placement in a NF. If the applicant /designated representative/LRI prefers placement in a NF, the ADSD Intake Specialist will provide information and resources to the applicant on who to contact to arrange facility placement.

d. The applicant will be given the right to request a Fair Hearing if not given a choice between HCBS Waiver services and NF placement.

4. The ADSD Intake Specialist will send the NMO-3010 "HCBS Waiver Eligibility Status Form" to DWSS for review and approval of the Medicaid application.

5. Once DWSS has approved the application, waiver services can be initiated.

   NOTE: If an applicant is denied for financial eligibility, DWSS will send a denial NOD to the applicant.

6. If the applicant is denied by ADSD for program eligibility, ADSD will submit a request to the DHCFP LTSS Unit requesting a denial NOD be sent to the applicant. The request must include the reason(s) for the denial. The DHCFP LTSS Unit will send the applicant the denial NOD. DHCFP will return a copy of the NOD to ADSD for their record.

7. Effective Date for Waiver Services

   The effective date for waiver services is determined by eligibility criteria verified by ADSD, the financial eligibility approval date by DWSS, or the residential facility for groups placement move in date, whichever is later.

   If the applicant is in an institution, the effective date cannot be prior to the date of discharge from the institution.

8. All applicants as applicable will be provided information regarding choice of case management providers by the ADSD Intake Specialist during the initial assessment and allowed the opportunity to choose a case management provider to be assigned once approved for waiver services. If a case management provider is not selected by the applicant/recipient, upon waiver approval one will be assigned by the ADSD Operations Agency based upon rotation and geographical location.

   Once an applicant has been approved and a case management provider is assigned, the ADSD Intake Specialist will forward all supporting documents within five business days to that provider for ongoing case management services.

   Supporting documents include a signed and dated SOC, a signed and dated HCBS Acknowledgement Form, copy of the ADSD Program Application, copy of the LOC, copy of the Disability Determination indicated on the NMO-3010, any supporting medical records, any notes from the Intake Specialist needed to support ongoing services, and a copy of the MAABD application submitted to DWSS.

   NOTE: If a case management provider is not selected within ten business days by the applicant, one will be assigned by the ADSD Operations Agency based upon a rotation schedule and provider capacity.

## 2303.~~43D~~ ~~DIRECT SERVICE~~ CASE MANAGEMENT

Case Management services assist participants in gaining access to needed waiver and other state plan services, as well as medical, social, educational, and other services, regardless of the funding source for the services to which access is gained.

## 2303.~~3E~~4A COVERAGE AND LIMITATIONS

Case managers must provide the recipient with the appropriate amount of case management services necessary to ensure the recipient is safe and receives sufficient services. The case management service is on an as needed basis. 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.

1. ~~Direct Service~~ Case ~~M~~management is ~~limited~~ provided to eligible recipients~~participants~~ enrolled in HCBS~~W~~ Waiver~~services~~ program~~s,~~ and ~~when case management is~~must be identified as a service on the POC. Case management providers are responsible for confirming the recipient's eligibility each month prior to rendering waiver services. The recipient has a choice ~~to have direct service~~of case management ~~services provided~~ providers who are actively enrolled with DHCFP under Provider Type (PT) 58. ~~by qualified state staff or qualifying provider agency staff.~~

   There are two components of case management services: administrative activities, and those activities that are considered billable:

   Administrative activities include:

   a. Travel

   b. Follow-up conducted resulting from a negative Participant Experience Survey (PES) finding.

   c. Request a Notice of Decision (NOD) when a negative action is taken (denial, suspension, termination, and reduction of services).

   d. Activities related to program eligibility including denials/Fair Hearings.

   e. Activities related to coordination of care for recipients in a suspended status.

   f. General administrative tasks including but not limited to scheduling of visits, voicemails, email communications with DHCFP, scanning and uploading documents, mailing provider lists and/or resources to recipient, telephoning providers for general availability, and outreach activities for solicitation.

   Billable case management activities include:

a. Completion of the SHA and LOC with the recipient (annual reassessment of eligibility and any change of condition).

b. POC development and follow-up for initiation of waiver services, including any activity related to the Prior Authorization (PA) requests approval and/or follow-up.

c. POC monitoring/follow-up (includes provider changes, a change in services/delivery, change in condition resulting in an amended POC, etc.).

d. Any mandated reporting activity (APS, HCQC, Law Enforcement, etc.)

e. Direct contact with recipients to aid in resource navigation, facilitation, and coordination with waiver and community resources.

f. Care Conference: collaboration and involvement in discharge planning from a long-term care 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.

g. Monitoring the overall provision of waiver services, to protect the health, welfare, and safety of the recipient and to determine that the POC goals are being met.

h. Monitoring and documenting the equality of care through contacts with recipients.

i. Ensuring that the recipient retains freedom of choice in the provision of services.

j. Notifying all affected providers of changes in the recipient's medical status, service needs, address, and location, or of changes of the status of the designated representative/LRI.

k. Notifying all affected providers of any unusual occurrence or change in status of a waiver recipient.

l. Notifying all affected providers of any recipient complaints regarding delivery of service or specific provider staff.

m. Notifying all affected providers if a recipient requests a change in the provider staff or provider agency.

n. Any adverse actions resulting in suspensions, terminations and/or reductions in services.

2. Upon assignment of an HCBS PD Waiver recipient, the case manager is responsible for conducting a face-to-face Social Health Assessment (SHA) and is used for the following:

   a. Address the recipient's needs, preferences, and individualized goals.

   b. Address ADLs, IADLs, service needs, and support systems.

   c. Gathering information regarding health status, medical history, and social needs.

   d. Consider risk factors, equipment needs, behavioral status, current support system, and unmet service needs.

   e. Ensures recipients are afforded the same access to the greater community as individuals who do not receive Medicaid HCBS, regardless of where they reside.

   f. Ensures recipients are afforded employment opportunities as desired, regardless of where they reside.

~~2303.3E COVERAGE AND LIMITATIONS~~

~~These services include:~~

~~1. Identification of resources and assisting recipients in locating and gaining access to waiver services, as well as needed medical, social, educational and other services regardless of the funding source;~~

3. The person-centered POC is developed in conjunction with the case manager, recipient/designated representative/LRI and/or a person of their choosing initially, annually, and when changes occur.

   If the recipient chooses to have a designated representative/LRI, they must complete the Designated Representative Attestation form. The case manager is required to document the designated representative/LRI who can sign documents and be provided information about the recipient's care.

   a. The initial and annual written POC must reflect the services and supports that are important for the recipient to meet the needs identified through the SHA, as well as what is important to the recipient regarding preference for the delivery of such services and supports and:

      1. Reflect that the setting in which the recipient resides was chosen by the recipient;

      2. Reflect opportunities to participate in integrated community settings, and seek employment or volunteer activities;

3. Reflect the recipient's strengths and preferences, and cultural considerations of the recipient;

4. Include identified personalized goals and desired outcomes, and reflect the services and supports (paid and unpaid) that will assist the recipient in achieving their identified goals;

5. Reflect risk factors and measures in place to minimize them, including back-up plans and strategies;

6. Be understandable to the recipient receiving the services and supports; and

7. Prevent the provision of unnecessary, duplicative, or inappropriate services and supports.

b. The recipient is afforded choice of service and providers, establishing the frequency, duration and scope, and method of service delivery are integrated in the planning process to the maximum extent possible.

NOTE: During the POC development, if the recipient chooses an LRI to provide personal care-like services, the case manager will provide a Designated Representative Attestation form to be signed by the recipient and/or the designated representative/LRI (who is NOT the paid caregiver) to guard against self-referral of LRIs. The designated representative/LRI indicated on the form is responsible for directing, monitoring, and supervising the provision of services by the caregiver.

c. The POC must identify all authorized waiver services; as well as other ongoing community support services that the recipient needs to remain in their home and live successfully in the community.

1. During the initial or annual POC development, and there is no chosen direct waiver provider, the service must still be listed on the POC to include the other elements with the provider as "to be determined (TBD)" and must be signed and dated by the recipient and/or designated representative/LRI. Documentation to support the efforts made by the case manager and the recipient to choose and assign a provider must be in the recipient's electronic record.

2. Once a provider has been selected, the POC must be updated to list the provider, along with signatures and date from the recipient and/or designated representative/LRI and provider during the next face-to-face visit.

d. The POC must include the recipient's chosen method and frequency of scheduled contacts (refer to section 2303.4A.4 – Person-Centered contacts for further information on frequency).

e. Changes to the POC

1. If there is a significant change (as defined in the MSM addendum) to the established LOC, the recipient must be reassessed and the LOC and POC must be updated within 30 days of the reported change.

2. The POC does not need to be revised when a recipient's waiver service needs change due to a temporary condition or circumstance lasting eight weeks or less. The case manager must document the change in the electronic case record.

3. When the case manager needs to update the current POC, the case manager can print the current POC and note any changes for the recipient and/or designated representative/LRI to sign. The case manager will formalize the updated POC within the electronic case file.

a. The POC with the handwritten changes/amendments containing the recipient and case manager's signature and date must be attached to the formalized POC and kept in the recipient's electronic case file.

b. A copy of the formalized POC and signed handwritten POC must be provided to the recipient and/or designated representative/LRI.

f. The POC must be finalized within 60 calendar days from waiver enrollment, date of reassessment, or significant change. The finalized POC must be signed and dated by the recipient and/or designated representative/LRI, case manager and provider.

g. The case manager is responsible to distribute the section of the POC which pertains to the specific waiver provider including the scope, frequency, duration, method of service delivery, the recipient's identified goals, and risk factors and mitigation.

h. Residential and Non-Residential Facilities (Assisted Living Facilities only)

When a modification is made on the POC that restricts a recipient's freedom of choice, it must be supported by a specific assessed need and justified in the POC. The direct service provider must notify the case manager to request modifications of the POC.

The case manager must document the following requirements on the POC:

1. Identify a specific and individualized assessed need;

2. Document the positive interventions and supports used prior to any modification to the POC;

3. Document less intrusive methods of meeting the need that have been tried but did not work;

4. Include a clear description of the condition that is directly proportionate to the specific assessed need;

5. Include regular collection and review of data to measure the ongoing effectiveness of the modification;

6. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;

7. Include an assurance that interventions and supports will cause no harm to the individual; and

8. Include the informed consent of the individual.

4. Person-Centered Contacts

a. Person-centered contacts are required to be delivered by the case management provider as agreed to in the signed POC. At a minimum, there must be a face-to-face visit with each recipient and/or designated representative/LRI annually. All other ongoing contact methods may be determined by the recipient.

NOTE: When case management is the only waiver service received, the case manager will continue to have monthly contact with the recipient and/or designated representative/LRI to ensure the health and welfare of the recipient. The duration, scope, and frequency of case management services billed to DHCFP must be adequately documented and substantiated by the case manager's narratives.

b. Person-centered contacts must be documented in the recipient's electronic record and must include at a minimum:

1. Monitoring of the overall provision of waiver services and determine that the personalized goals identified in the POC are being met.

2. Monitoring and documenting the quality of care to include assurance that the health and safety of the recipient is maintained:

a. Quality of care includes the identification, remediation and follow-up of health and safety, risk factors, needs and concerns (to include

changes in provider and/or back-up plan or support network) of the recipient, waiver service satisfaction and whether the services are promoting the personalized goals stated in the POC. The case manager also assesses the need for any change in services or providers.

b. If a recipient resides in a residential setting (AL facility), the case manager must inquire on the recipient's satisfaction in the residential setting.

3. Case managers must demonstrate due diligence to hold ongoing contacts as outlined in the POC (frequency and method). Ongoing contacts are required, and every attempt to contact the recipient should be documented. At least three telephone calls must be completed on separate days, if no response is received after the third attempt, a letter must be sent to the recipient requesting a return contact. If the recipient fails to respond by the date indicated in the letter, the recipient may be terminated.

4. If an LRI is chosen by the recipient to provide paid personal care-like services in their private home, the case manager will conduct more frequent home visits (no less than bi-annually in person and quarterly by telephone) to ensure the recipient is satisfied with the waiver services and caregiver.

5. Annual Reassessments

a. The recipient's LOC and SHA must be reassessed at a minimum annually.

1. Once the case manager has completed the reassessment including the LOC, SHA and POC, the case manager will submit the completed LOC to the ADSD Operations Agency for approval.

2. Once received by the ADSD Operations Agency, a review of the LOC will be conducted, and a decision will be supplied to the case manager provider within five business days.

3. Upon receipt of the approval from the ADSD Operations Agency, the case manager will complete the PA process for continued services.

4. If the ADSD Operations Agency determines the LOC is not approved, communication will be delivered to the case management provider within five business days identifying the outcome and the next steps as appropriate.

b. The POC is updated using the SHA which is completed in collaboration with the case manager and the recipient and/or designated representative/LRI, and/or person of their choosing, who may not be the paid caregiver.

c. The annual POC is required to be signed no more than 60 calendar days from the date of the reassessment.

6. The case manager may provide support to the recipient and/or designated representative/LRI by assisting with the completion of the DWSS Annual Redetermination (RD).

~~2. Coordination of multiple services and/or providers;~~

~~3. Monitoring the overall provision of waiver services, in an effort to protect the safety and health of the recipient and to determine that the POC goals are being met;~~

~~4. Monitoring and documenting the quality of care through monthly contact:~~

~~a. The direct service case manager must have a monthly contact with each waiver recipient and/or the recipient's authorized representative; this may be a telephone contact. At a minimum, there must be a face-to-face visit with each recipient once every six months. More contacts may be made if the recipient has indicated a significant change in his or her health care status or is concerned about his or her health and/or safety.~~

~~b. When recipient service needs increase, due to a temporary condition or circumstance, the direct service case manager must thoroughly document the increased service needs in their case notes. The POC does not need to be revised for temporary conditions or circumstances. A temporary condition or circumstance is defined as an increase or decrease in service needs for a period not to exceed 30 days.~~

~~c. During the monthly contact, the direct service case manager monitors and documents the quality of care of the recipient. Quality of care includes the identification, remediation and follow-up of health and safety issues, needs and concerns of the recipient, waiver service satisfaction and whether the services are promoting goals stated in the POC. The direct service case manager also assesses the need for any change in services or providers and communicates this information to the administrative case manager.~~
~~NOTE: If a recipient has an independent contractor, the direct service case manager may review the recipient daily record for completion and accuracy. The case manager will provide training to independent contractors in the completion and use of daily records if needed.~~

~~5.~~7. ~~Making certain that the~~Ensure recipient~~s~~ retain~~s~~ freedom of choice in the provision of service~~s~~;. During the ongoing contact with the recipient the case manager must narrate if a recipient indicates that they are not satisfied with their current waiver services;

~~6.~~8. Notifying all affected providers of any unusual occurrences or changes in the recipient's medical status, service needs, address, ~~and location,~~ or ~~of changes of the status of legally responsible individuals or authorized~~ designated representative LRI;

~~7. Notifying all affected providers of any unusual occurrence or change in status of a waiver recipient;~~

~~8.~~9. Notifying all affected providers of any recipient complaints regarding delivery of service or specific provider staff;

~~9.~~10. Notifying all affected providers if a recipient requests a change in the provider staff or provider agency~~; and~~

~~7. Case Managers must provide recipients with appropriate amount of case management services necessary to ensure the recipient is safe and receives sufficient services. Case management will be considered an "as needed" service. Case managers must continue to have monthly contact with recipients and/or the recipients authorized representative of at least 15 minutes, per recipient, per month. The amount of case management services must be adequately documented and substantiated by the case manager's notes.~~

11. Case closure activities upon termination of service eligibility, to include notifying DWSS and DHCFP LTSS, and closing any existing prior authorizations.

12. If an ongoing recipient chooses to change case management providers, they may request this by contacting the ADSD Operations Agency as outlined in the SOC. The ADSD Operations Agency will provide the recipient with a list of case management providers for them to choose from. If a new case management provider is not chosen within ten calendar days, the currently assigned case manager will continue to provide the service.

    a. Upon provider selection by the recipient and/or designated representative/LRI, the Operations Agency will notify the selected case management provider agency of the assignment.

    b. The previous case management agency will be given ten business days to provide all requested documentation to the ADSD Operations Agency to assist with the transfer of the recipient to the chosen case management provider.

    c. The new case management provider agency must be reflected on the POC which is required to be signed during the next face-to-face visit.

13. Case managers are responsible for confirming the recipient's Medicaid eligibility each month prior to rendering waiver services.

2303.~~4B3F~~ ~~DIRECT SERVICES CASE MANAGEMENT~~ PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2303.2B: ~~Verification of compliance with these administrative requirements~~ must ~~be provided~~:

1. Public case managers must meet the following qualifications:

   a. Be currently licensed as a Social Worker by the State of Nevada Board of Examiners for Social Workers, licensure as a RN by the Nevada State Board of Nursing or have a professional license or certificate in a medical specialty applicable to the assignment.

   b. Have a valid driver's license and means of transportation to enable face-to-face visits.

   c. Adhere to HIPAA requirements.

   d. Complete an FBI criminal background check.

2. Private case management provider agencies must:

   a. Provide documentation showing taxpayer identification number (SS-4 or CP575 or W-9).

   b. Provide proof of Nevada Secretary of State Business license

   c. Provide proof of Worker's Compensation Insurance

   d. Provide proof of an Unemployment Insurance Account

   e. Provide proof of Commercial General Liability of not less than $2 million general aggregate and $1million 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.

   f. Provide proof of Commercial Crime Insurance for employee dishonesty with a minimum of $25,000 per loss. The policy must name DHCFP as an additional insured.

   g. If you provide transportation in any owned, leased, hired and non-owned vehicles you must also provide:

      1. ~~1.~~ 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."

h. Provide a signed Business Associate Addendum (NMH-3820). The Addendum is available at https://www.medicaid.nv.gov on the "Provider Enrollment" webpage under "Required Enrollment Documents."

~~1.~~i. Establish ~~A~~a fixed business landline telephone number published in a public telephone directory.

~~2.~~j. Have ~~A~~a business office accessible to the public during established and posted business hours.

k. Case managers/employees of the private case management agency must also meet the following qualifications:

1. Be currently licensed as a Social Worker by the State of Nevada Board of Examiners for Social Workers, licensure as a RN by the Nevada State Board of Nursing or have a professional license or certificate in a medical specialty applicable to the assignment.

2. Have a valid driver's license and means of transportation to conduct home visits.

3. Adhere to HIPAA requirements.

4. Complete an FBI criminal background check.

~~Employees of the case management provider agency who provide direct service case management services must be 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, have at least one year experience as a case manager and must have a valid driver's license. Employees must pass a State and FBI criminal background check. In addition, providers must meet and comply with all provider requirements as specified in MSM Chapters 100 and/or 3500.~~

2303.~~4C3G~~ RECIPIENT RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2303.2C, the recipient must:

1. Participate in the ~~waiver assessment, monthly~~ongoing contacts and reassessment process, accurately representing ~~his or her~~their skill level needs, preferences~~wants~~, resources, and goals.

2. Together with the ~~waiver~~ case manager, develop and/or review and sign, and date the POC. If the recipient is unable to provide a signature due to cognitive ~~intellectual~~ and/or physical limitations, this will be clearly documented in the recipient file. ~~The provider will initial after the daily services are delivered, with a full signature of the provider on each daily record.~~

3. Choose a Medicaid enrolled case management provider~~to have direct service case management provided by qualifying state staff or qualifying provider agency staff~~.

## 2303.~~4~~5 HOMEMAKER SERVICES

Homemaker services consist of IADLs such as general household tasks, meal preparation, essential shopping, and laundry. These services are provided when the individual regularly responsible for these activities is temporarily absent or unable to manage their private residence and is necessary to avoid placement in an institution. These services are provided to individuals who are not authorized to receive State Plan PCS and require assistance with IADLs.

### 2303.~~4A~~5A COVERAGE AND LIMITATIONS

1. Homemaker services are provided at the recipient's home, or place of residence (community setting~~by individuals or agencies under contract with the DHCFP.~~

2. ~~Homemaker s~~Services must be directed to the individual recipient and related to their health and welfare. ~~are provided when the individual regularly responsible for these activities is temporarily absent or unable to manage the home.~~

3. ~~The~~ DHCFP or its Fiscal Agent and case management providers are not responsible for the replacement of goods damaged in the provision of service.~~is not responsible for replacing goods damaged in the provision of service.~~

4. Homemaker services include:

   a. General household tasks:~~general cleaning,~~ including mopping floors, vacuuming, dusting, ~~cleaning the stove,~~ changing and making beds, washing dishes, defrosting and cleaning the refrigerator, cleaning bathrooms and kitchens~~keeping bathrooms and the kitchen clean~~, and washing windows as high as the homemaker can reach while standing on the floor;

   b. Essential shopping to obtain prescribed drugs, medical ~~for food and needed~~ supplies, groceries, and other household items required specifically for the health and maintenance of the recipient;

   c. ~~planning and preparing varied m~~Meal~~s~~ preparation: menu planning, storing, preparing, serving food, buttering bread and plating food~~, considering both cultural~~

~~and economic standards of the recipient, preparing tray meals when needed, and preparing special diets under medical supervision~~;

d. Laundry services: washing, drying, and folding ~~ironing and mending~~ the recipient's personal laundry and linens (sheets, towels, etc.), excluding ironing. The recipient is responsible for ~~pays~~ any laundromat and/or cleaning fees;

e. ~~a~~Assisting the recipient and family members ~~legally responsible individuals~~ or caregivers in learning a homemaker routines and skills, so the recipient may carry on normal living when the homemaker is not present;

f. ~~a~~Accompanying the recipient to homemaker activities such as shopping or the laundromat. Any transportation to and from these activities is not reimbursable as a Medicaid expense;

g. ~~r~~Routine clean-up of waste ~~after~~ for up to two household pets. Walking a pet is not included unless it is a service animal.

h. Additional homemaker activities may be approved on a case-by-case basis.

~~4.~~5. Activities the homemaker shall not perform and for which Medicaid will not pay include~~, but are not limited to~~ the following:

a. ~~t~~Transporting ~~(as the driver)~~ the recipient in a private car;

b. ~~c~~Cooking and cleaning for the recipient's guests, other household members or for the purpose of entertaining;

c. ~~r~~Repairing electrical equipment;

d. ~~i~~Ironing ~~sheets~~and mending;

e. ~~g~~Giving permanents, dying, or cutting hair;

f. ~~a~~Accompanying the recipient to appointments, social events, or in-home socialization;

g. ~~w~~Washing walls;

h. ~~m~~Moving heavy furniture, climbing on chairs or ladders;

i. ~~p~~Purchasing alcoholic beverages ~~which were~~that are not prescribed by the recipient's physician;

j. ~~d~~Doing yard work such as weeding or mowing lawns, trimming trees, shoveling non-essential snow-~~-~~covered areas and vehicle maintenance~~.~~; or

k. Providing care to pets unless the animal is a certified service animal.

6. Live-in LRIs are limited to up to two hours per week, for non-live-in LRIs, the service hours will be based on the case manager's assessment of the recipient's living conditions (e.g. living alone, risk level).

2303.~~4B~~5B ~~HOMEMAKER~~ PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2303.2B, Homemaker Providers must:~~following requirements listed, please reference Section 2303.3B of this chapter regarding Provider Responsibilities.~~

1. Provide~~rs~~ adequate~~are required to arrange and receive~~ training related to homemaking assistance appropriate for recipients with physical disabilities completed initially and annually ~~household care, including good nutrition, special diets, meal planning and preparation, shopping information, housekeeping techniques, and maintenance of a clean, safe and healthy environment~~.

~~2. A legally responsible individual may not be paid for homemaker services.~~

~~3. The DHCFP is not responsible for replacement of goods damaged in the provision of service.~~

~~4. Service must be prior authorized and documented in an approved EVV.~~

~~5.~~2. ~~Providers are responsible to e~~Ensure that EVV requirements and expectations are met, including the documentation of all services in approved EVV system~~.~~

3. The service mut be prior authorized by the case manager and documented in an approved EVV system.

2303.5C RECIPIENT RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2303.2C, the recipient must:

1. Agree to utilize an approved EVV system for the waiver services being received from the provider agency.

2. Confirm services were provided by electronically signing or initialing, as appropriate per POC, the EVV record that reflects the service rendered. If IVR is utilized, a vocal confirmation is required.

## 2303.6 RESPITE CARE

Respite Care Services are provided to recipients unable to care for themselves. This service is provided on a short-term basis because of the absence or need for relief of those persons normally providing the care. Respite providers perform general assistance with ADLs and IADLs as well as provide supervision to functionally impaired recipients in their private home or place of residence (community setting).

## 2303.6A COVERAGE AND LIMITATIONS

1. Respite services may be for 24-hour periods~~care is provided for relief of the primary unpaid caregiver~~.

2. Respite care is limited to 120 hours or the duration of the POC~~per waiver year per individual~~.

3. Services must be prior authorized by the case manager~~Respite care is only provided in the individual's home or place of residence~~.

## 2303.6B ~~RESPITE CARE~~ PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities ~~following requirements~~ listed in, ~~reference~~ Section 2303.~~3~~2B, ~~of this Chapter regarding Provider Responsibilities~~Respite providers must:~~.~~

~~Respite providers must:~~

~~perform general assistance with ADLs and IADLs and provide supervision to functionally impaired recipients in their homes to provide temporary relief for a primary caregiver;~~

~~have the ability to read and write and to follow written or oral instructions;~~

1. Provide adequate training related to personal care assistance appropriate for recipients with physical disabilities completed initially and annually to include training on personal hygiene needs and techniques for assisting with ADLs, such as bathing, grooming, skin care, transfer, ambulation, exercise, feeding, dressing, and use of adaptive aids and equipment, homemaking, and household care;

~~have had experience and or training in providing the personal care needs of people with disabilities~~;

2. ~~m~~Meet the requirements of NRS 629.091, Section 2303.3B of this Chapter, and MSM Chapter 2600 if a respite provider is providing attendant care services that are considered skilled services; and

~~demonstrate the ability to perform the care tasks as prescribed;~~

~~be tolerant of the varied lifestyles of the people served;~~

~~identify emergency situations and act accordingly, including completion of CPR certification which may be obtained outside the agency;~~

~~have the ability to communicate effectively and document in writing services provided;~~

~~maintain confidentiality regarding details of case circumstances;~~

~~arrange training in personal hygiene needs and techniques for assisting with ADLs, such as bathing, grooming, skin care, transfer, ambulation, exercise, feeding, dressing, and use of adaptive aids and equipment, homemaking and household care.~~

~~Services must be prior authorized and documented in an approved EVV System.~~

3. Providers are responsible to ensure that EVV requirements and expectations are met, including the documentation of all services in approved EVV system.

4. Services must be prior authorized by the case manager and documented in an approved EVV system.

## 2303.6C RECIPIENT RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2303.2C, the recipient must:

1. Agree to utilize an approved EVV system for the waiver services being received from the provider agency.

2. Confirm services were provided by electronically signing or initialing, as appropriate per POC, the EVV record that reflects the service rendered. If IVR is utilized, a vocal confirmation is required.

## 2303.~~12~~7 ATTENDANT CARE SERVICES

Attendant Care Services are an extension of State Plan Personal Care Services (PCS) intended to support an individual to remain independent within the community. These services are authorized by case managers to assist the recipient's need for ADL and IADL assistance based upon functional deficits.

### 2303.~~12~~7A COVERAGE AND LIMITATIONS

The scope and nature of these services do not otherwise differ from State Plan PCS furnished under the State Plan. Attendant Care Services are only provided to individuals aged 21 and over when the limits of the State Plan Option PCS are exhausted. Refer to MSM chapter 3500 for further

information. ~~Extended State plan personal care attendant service may include assistance with eating, bathing, dressing, personal hygiene, ADLs, shopping, laundry, meal preparation and accompanying the recipient to appointments as necessary to enable the individual to remain in the community. The service may include hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically disabled individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. This service may include skilled services to the extent permitted by State law. This service may include an extension of task completion time allowed under the state plan with documented medical necessity.~~

1. Where possible and preferred, ~~by the~~ recipients, ~~he/she~~ will direct ~~his/her~~their own service through an ~~Intermediary Services Organization (~~ISO~~)~~. Refer to MSM Chapter 2600. Under the ISO model, ~~When~~ the recipient can recruit,~~s~~ ~~and~~ select,~~s~~ or terminate a caregiver~~,~~. ~~the individual is referred to the ISO for hire. The recipient may also terminate the assistant. When utilizing this option, the recipient will work with his/her case manager to identify an appropriate back up plan.~~ If this option is not used, the recipient will choose a provider agency that will otherwise recruit, screen, schedule ~~assistants~~caregivers, provide backup and assurance of emergency assistance.

2. Extended personal care attendant services in the recipient's ~~plan of care~~POC may include assistance with ADLs and IADLs~~:~~.

   ~~eating;~~

   ~~bathing;~~

   ~~dressing;~~

   ~~personal hygiene;~~

   ~~ADLs;~~

~~h~~Hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically disabled individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function.

3. Flexibility of Services

   Flexibility of service delivery, which does not alter medical ~~necessity~~necessity, may occur within a single week period without an additional authorization. Reference 2303.~~3~~2B.~~1.e~~7 of this chapter for details.

2303.~~12~~7B ~~ATTENDANT CARE~~ PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities~~following requirements~~ listed in 2303.2B, the provider

must:~~,~~ ~~reference Section 2303.3B of this Chapter regarding Individual Provider Responsibilities.~~

~~Personal care attendants may be members of the individual's family. However, payment will not be made for services furnished by legally responsible individuals.~~

1. When the provision of services includes self-directed skilled~~an unskilled provider completing skilled care~~, qualifications and requirements must be followed ~~as~~ in accordance with NRS 629.091, and MSM Chapter 2600.

2. ~~Providers must d~~Demonstrate the ability to:

   a. ~~p~~Perform the care tasks as prescribed;

   b. ~~i~~Identify emergency situations and to act accordingly~~, including CPR certification which may be obtained outside the agency~~and;

   ~~m~~Maintain confidentiality ~~in regard~~regarding ~~to~~ the details of case circumstances~~; and~~

   ~~document in writing the services provided.~~

3. Provide adequate training related to personal care assistance appropriate for recipients with physical disabilities completed initially and annually to include~~Provider Agencies must arrange training in~~:

   a. ~~p~~Procedures for arranging backup when not available, agency contact person(s), and other information as appropriate. (Note: This material may be provided separate from a training program as part of the provider's orientation to the agency.)

   b. Ppersonal hygiene needs and techniques for assisting with ADLs, such as bathing, grooming, skin care, transfer, ambulation, exercise, feeding, dressing, and use of adaptive aids and equipment.

   c. ~~h~~Home making and household care, including good nutrition, special diets, meal planning and preparation, essential shopping, housekeeping techniques, and maintenance of a clean, safe, and healthy environment.

~~Service must be prior authorized and documented in an approved EVV System.~~

4. Providers ~~is~~are responsible to ensure that EVV requirements and expectations are met, including the documentation of all services in an approved EVV System.

5. Services must be prior authorized by the case manager and documented in an approved EVV system.

2303.7C RECIPIENT RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2303.2C, the recipient must:

1. Agree to utilize an approved EVV system for the waiver services being received from the provider agency.

2. Confirm services were provided by electronically signing or initialing, as appropriate per POC the EVV record that reflects the service rendered. If IVR is utilized, a vocal confirmation is required.

## 2303.~~10~~8 ASSISTED LIVING SERVICES

Assisted Living (AL) services are all inclusive services furnished by an AL services provider that meet the HCBS setting requirements. AL services are intended to provide all support service needed in the community and may include personal care, homemaker, chore, attendant care, meal preparation, companion, medication oversight (to the extent permitted under state law), transportation, diet and nutrition, orientation and mobility, community mobility/transportation training, advocacy for related social services, health maintenance, active supervision, home and community safety training, provided in a home-like environment in a licensed community care facility.

This service may include skilled nursing care to the extent permitted by state law, nursing and skilled therapy services are incidental rather than integral to the provision of AL services.

## 2303.~~10~~8A COVERAGE AND LIMITATIONS

1. ~~Assisted living~~AL ~~services~~ are all inclusive services furnished by the assisted living provider. ~~Assisted living services are meant to provide all support services needed in the community and may include personal care, homemaker, chore, attendant care, meal preparation, companion, medication oversight (to the extent permitted under state law), transportation, diet and nutrition, orientation and mobility, community mobility/ transportation training, advocacy for related social services, health maintenance, active supervision, home and community safety training, therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility. Services provided by a third party must be coordinated with the assisted living facility. This service may include skilled or nursing care to the extent permitted by state law. Nursing and skilled therapy services are incidental, rather than integral to the provision of assisted living services.~~ Payment is not to be made for ~~24 hour~~24-hour skilled care. If a recipient chooses ~~assisted living~~ AL services, other individual waiver services may not be provided, except case management services.

2. Thi~~s~~se service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promot~~ing~~es maximum dignity and independence, and ~~to~~ provides supervision, safety, and security.

3. ~~Assisted living~~AL providers are expected to furnish a full array of services except when another Federal program is required to provide the service. Other individuals or agencies may also furnish care directly, or under arrangement with the ~~assisted living~~AL provider, but the care provided by other entities supplements that provided by the ~~assisted living~~AL provider and does not supplant it.

4. Federal Financial Participation (FFP) is not available for room and board, items of comfort, or the cost of facility maintenance, upkeep, and improvement.

5. Personalized care furnished to individuals who choose to reside in an AL facility based on their individualized POC, which is developed with the recipient, people chosen by the recipient, caregivers, and the case manager. Care must be furnished in a way that fosters the independence of each recipient.

2303.~~10~~8B ~~ASSISTED LIVING~~ PROVIDER RESPONSIBILITIES

~~The assisted living environment must evidence a setting providing:~~

~~living units that are separate and distinct from each other;~~

~~a central dining room, living room or parlor and common activity center(s) except in the case of individual apartments;~~

~~24 hour on-site response staff.~~

~~All persons performing services to recipients from this category must have criminal history clearances obtained from the FBI through the submission of fingerprints to the FBI. In addition, provider agencies are required to conduct routine screenings on all applicants who will perform services to recipients to ensure the health and welfare of recipients and to make every effort possible to prevent recipient abuse. Reference Section 2303.3B2.d.~~

~~Providers must arrange training in personal hygiene needs and techniques for assisting with ADLs such as bathing, dressing, grooming, skin care, transfer, ambulation, exercise, feeding, use of adaptive aids and equipment, identifying emergency situations and how to act accordingly.~~

~~Must have current CPR certification which may be obtained outside the agency prior to initiation of services to a Medicaid recipient.~~

~~Caregiver Supervisors will:~~

~~possess at least one year of supervisory experience and a minimum of two years experience working with adults with physical disabilities, including traumatic brain injury.~~

~~demonstrate competence in designing and implementing strategies for life skills training and independent living.~~

~~possess a bachelor's degree in a human service field preferably, or education above the high school level combined with the experience noted in paragraph (a) above.~~

~~Supporting Qualifications of the Caregiver Supervisor are:~~

~~experience in collecting, monitoring, and analyzing service provision; ability to identify solutions and satisfy staff/resident schedules for site operations.~~

~~ability to interpret professional reports.~~

~~knowledge of life skills training, personal assistance services, disabled advocacy groups, accessible housing, and long-term care alternatives for adults with physical disabilities and/or traumatic brain injuries.~~

~~dependable, possess strong organization skills and have the ability to work independent of constant supervision.~~

~~Assisted Living Attendants~~

~~Assisted living attendants shall provide personal care services, community integration, independent living assistance, and supervisory care to assist the recipient in following the POC. Assisted living attendants shall possess:~~

~~a high school diploma or GED.~~

~~some post secondary educational experience is desired.~~

~~a minimum of two positive, verifiable employment experiences.~~

~~two years of related experience is desired.~~

~~job experience demonstrating the ability to teach, work independently without constant supervision, and demonstrating regard and respect for recipients and co-workers.~~

~~verbal and written communication skills.~~
~~the ability to handle many details at the same time.~~
~~the ability to follow through with designated tasks.~~

~~knowledge in the philosophy and techniques for independent living for people with disabilities.~~

~~if the attendant is providing attendant care services, that include skilled services, the attendant must meet the requirements of NRS 629.091.~~

~~a current CPR certificate.~~

~~Supporting Qualifications of the assisted living attendant are:~~

~~dependability, able to work with minimal supervision;~~

~~demonstrates problem solving ability;~~

~~the ability to perform the functional tasks of the job.~~

~~The service must be prior authorized.~~

In addition to the provider responsibilities listed in Section 2303.2B providers must:

1. Be licensed and maintain standards as outlined by HCQC under NRS/NAC 449 "Medical and other related entities".

2. Adhere to all HCQC and ADSD training requirements specific to the waiver population being cared for at the AL facility completed initially and annually.

3. AL facility providers must:

   a. Ensure that HCBS Settings requirements and expectations are followed. The HCBS Settings Regulation supports enhanced quality in HCBS programs, adds protections for individuals receiving services and supports through Medicaid's HCBS programs have full access to the benefits of community living and can receive services in the most integrated setting.

   b. Notify the case manager within three business days when the recipient states the desire to leave the facility.

   c. Participate with the case manager in discharge planning.

   d. Notify the case manager within one working day if the recipient's living arrangements have changed, eligibility status has changed, or if there has been a change in health status that could affect recipient's health, safety, or welfare.

   e. ~~e.~~ Notify the case manager of any recipient complaints regarding delivery of service or specific staff of the setting. If the recipient is not satisfied with their living arrangements or services, the case manager will work with the recipient and the provider to resolve any areas of dissatisfaction. If the recipient makes the decision to relocate to another setting, the case manager will provide information and facilitate visits to other contracted settings.

f. Maintain privacy, dignity, and respect during the provisions of services, and ensure living units are not entered without permission.

g. Allow recipients to have visitors of their choosing and access to food at any time.

h. Ensure the facility is physically accessible to the recipient.

i. Conduct business in such a way that the recipient is free from coercion and restraint and retains freedom of choice. AL Facilities must render services based on the recipient's choice, direction, and preferences.

j. Coordinate transportation to and from the setting to the hospital, a NF, routine medical appointment, and social outings organized by the facility. Recipients may choose to enjoy their privacy, participate in physical activities, relax, or associate with other residents. Recipients may go out with family members or friends at any time and may pursue personal interests outside of the residence.

NOTE: For all Medicaid covered services refer to MSM Chapter 1900 – Transportation Services.

k. Accept only those residents who meet the requirements of HCQC licensure and certification.

l. Provide services to PD Waiver recipients in accordance with the recipient's POC.

m. Not use or disclose any information concerning a recipient for any purpose not directly connected with the administration of the PD Waiver except by written consent of the recipient or designated representative/LRI.

n. Have sufficient caregivers present at the facility to conduct activities and provide care and protective supervision for the residents at all times. The provider must comply with HCQC staffing requirements for the specific facility type.

o. Have 24-hour on-site staff to meet scheduled or unpredictable needs and provide supervision, safety and security.

p. Not use Medicaid waiver funds to pay for the recipient's room and board.

q. Ensure that recipients are provided the opportunity to seek employment and work in competitive integrated settings, engage in community life, control personal resources (such as access to bank accounts), and receive services in the community to the same degree as individuals not receiving Medicaid HCBS.

r. Allow each recipient privacy in their sleeping or living unit:

1. Units or rooms have lockable doors. A bedroom or bathroom door in a residential group setting which is equipped with a lock must open with a single motion from the inside. Staff must knock before entering; recipients have the right to choose who enters the bedroom.

2. Recipients sharing units have a choice of roommate.

3. Encourage recipients to utilize personal furniture, furnishing, photo and decorative items to personalize their living space.

s. Not have a lease or other agreement that differs from those individuals who do not receive Medicaid HCBS.

The provider must have a written agreement that includes the following:

1. Provide at least a 30-calendar day notification to the recipient before transferring or discharging them with the exception of a voluntary transfer or discharge, or the requirement to transfer or discharge the recipient to another facility because the condition of the recipient necessitates a higher level of care;

2. Provide the recipient and case manager with written notice of the intent to transfer or discharge the recipient; and

3. Allow the recipient and other person authorized by the recipient the opportunity to meet in person with the administrator of the facility to discuss the proposed transfer of discharge within 10-calendar days after providing written notice.

t. Notify the recipient's case manager when a modification is made on the POC that restricts the recipient's freedom of choice.

4. Recipient Records

a. Each provider must have a file for each recipient. In the recipient's file, the provider must have a copy of the current POC and maintain daily records, fully documenting the scope and frequency of services as specified on the POC, and lease or other agreement.

The documentation will include the recipient's acknowledgment of service. If the recipient is unable to provide the acknowledgment due to cognitive and/or physical limitations, this will be clearly documented on the POC, indicating the designated representative/LRI. Recipients without a designated representative/LRI can select an individual to act on their behalf by completing the Designated Representative Attestation Form. The case manager will be required to document the designated

representative/LRI who can sign documents and be provided information about the recipient's care.

b. The provider will initial after the daily services are delivered, with a full signature of the provider on each daily record. If a provider elects to use electronic signatures, they must have weekly printouts of the daily record in the recipient's file or make them available upon request. For electronic signatures, systems and software products must include protection against modifications, with administrative safeguards that correspond to policies and procedures of ADSD. The individual whose name is on the alternate signature method and the provider bear the responsibility for the authenticity of the information being attested to.

c. Periodically, DHCFP and/or ADSD staff may request daily service documentation to compare it to submitted claims. These records must be maintained by the provider for at least six years after the date the claim is paid.

d. Services for waiver recipients residing in an AL Facility should be provided as specified on the POC.

e. If fewer services are provided than are authorized on the POC, the reason must be adequately documented in the daily record and communicated to the Case Manager.

2303.8C RECIPIENT RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2303.2C, the recipient must:

1. Cooperate with the providers of an AL Facility in the delivery of services.

2. Report any problems with the delivery of services to the AL Facility administrator and/or case manager.

2303.~~5~~9 CHORE SERVICES

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. These services are provided only in cases where the recipient, anyone else in the household, landlord, community volunteer/agency, or third-party payer is not capable of performing nor responsible for the provision of these services, or financially able to provide these services, and without these services, the recipient would be at risk of institutionalization.

2303.~~5A~~9A COVERAGE AND LIMITATIONS

1. The service must be identified in the POC and approved by the case manager.

~~1.~~2. This service includes heavy household chores such as:

a. ~~c~~Cleaning windows and walls;

b. ~~s~~Shampooing carpets, tacking down loose rugs and tiles;

~~c. tacking down loose rugs and tiles;~~

~~d.~~c. ~~m~~Moving ~~heaving~~ heavy items of furniture to provide safe access;

~~e.~~d. ~~m~~Minor home repairs;

~~f.~~e. ~~r~~Removing trash and debris from the yard; and

~~g.~~f. ~~p~~Packing and unpacking for the purpose of relocation~~boxes~~.

~~4.~~3. ~~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. These services are provided only in cases where neither the recipient, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer/agency or third party payer is capable of, or responsible for, their provision and without these services the recipient would be at risk of institutionalization.~~ This is not a skilled, professional service.

~~5.~~4. In the case of rental property, the responsibility of the landlord pursuant to the lease agreement, must be examined and confirmed prior to any authorization of service. The legal responsibility of the landlord to maintain and ensure safety on the rental property shall supersede any waiver ~~program~~ covered services.

## 2303.~~5B~~9B ~~CHORE SERVICES~~ PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities~~following requirements~~ listed, in Section 2303.2B, individuals performing Chore Services must:~~reference Section 2303.3B of this Chapter regarding Provider Responsibilities.~~

1. Provide adequate training appropriate for recipients with physical disabilities completed initially and annually to include training in performing heavy household activities and minor home repair; and

~~1.~~2. ~~Persons performing heavy household chores and minor home repair services need to ~~m~~~~Maintain the home in a clean, sanitary, and safe environment. if performing heavy household chores and minor home repair services.

3. Providers are responsible for ensuring ~~to ensure~~ that EVV requirements and expectations are met, including the documentation of all services in approved EVV system.

4. Services must be prior authorized by the case manager and documented in an approved EVV system.

2303.9C RECIPIENT RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2303.2C, the recipient must:

1. Agree to utilize an approved EVV system for the waiver services being received from the provider agency.

2. Confirm services were provided by electronically signing or initialing, as appropriate per POC, the EVV record that reflects the service rendered. If IVR is utilized, a vocal confirmation is required.

~~2303.6 RESPITE CARE~~

~~2303.6A COVERAGE AND LIMITATIONS~~

~~1. Respite care is provided for relief of the primary unpaid caregiver.~~

~~2.1. Respite care is limited to 120 hours per waiver year per individual.~~

~~3.1. Respite care is only provided in the individual's home or place of residence.~~

~~2303.6B RESPITE CARE PROVIDER RESPONSIBILITIES~~

~~In addition to the following requirements listed, reference Section 2303.3B of this Chapter regarding Provider Responsibilities.~~

~~1. Respite providers must:~~

~~1. perform general assistance with ADLs and IADLs and provide supervision to functionally impaired recipients in their homes to provide temporary relief for a primary caregiver;~~

~~2.1. have the ability to read and write and to follow written or oral instructions;~~
~~3.1. have had experience and or training in providing the personal care needs of people with disabilities;~~

~~4.1. meet the requirements of NRS 629.091, Section 2303.3B of this Chapter, and MSM Chapter 2600 if a respite provider is providing attendant care services that are considered skilled services;~~

~~5.1. demonstrate the ability to perform the care tasks as prescribed;~~

~~6.1. be tolerant of the varied lifestyles of the people served;~~

~~7.1. identify emergency situations and act accordingly, including completion of CPR certification which may be obtained outside the agency;~~

~~8.1. have the ability to communicate effectively and document in writing services provided;~~

~~9.1. maintain confidentiality regarding details of case circumstances;~~

~~10.1. arrange training in personal hygiene needs and techniques for assisting with ADLs, such as bathing, grooming, skin care, transfer, ambulation, exercise, feeding, dressing, and use of adaptive aids and equipment, homemaking and household care.~~

~~11.1. Services must be prior authorized and documented in an approved EVV System.~~

~~12.1. Providers are responsible to ensure that EVV requirements and expectations are met, including the documentation of all services in approved EVV system.~~

## 2303.~~7~~10 ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS (EAA)

Environmental Accessibility Adaptations are physical adaptations to the residence of the recipient or the recipient's family that have been identified within the recipient's POC. These adaptations must ensure the health, welfare, and safety of the recipient and/or enable the recipient to function with greater independence within their own home.

## 2303.~~7A~~10A COVERAGE AND LIMITATIONS

1. Adaptations may include the purchase of environmental controls, the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems necessary to accommodate the medical equipment and supplies needed for the welfare of the recipient. ~~Adaptations must be prior authorized and are subject to legislative budget constraints.~~

2. All services, modifications, improvements, or repairs must be provided in accordance with applicable state or local housing and building codes.

3. Providers who are furnishing EAA services to PD waiver recipients will be able to bill for an assessment fee (maximum of one hour) and a flat rate mileage for a single transport over 30 miles. The purpose of the addition of the assessment fee is to ensure recipients receive maximum services and for waiver providers to have the ability to properly identify needed

adaptations. The assessment and travel fees can be billed separately from the maximum amount limit per calendar year to complete the job (material and labor costs).

4. Rental properties must receive written approval from the landlord prior to authorizing any EAA.

~~4.~~5. Excluded Adaptations

a. Improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc.

b. Adaptations which increase the total square footage of the home except when necessary to complete an adaptation, for example, ~~in order~~ to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair.

2303.~~7B~~10B ~~ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS~~ PROVIDER RESPONSIBILITIES

1. All sub-contractors must be licensed or certified if applicable. Modifications, improvements, or repairs must be made in accordance with local and state housing and building codes.

2. Must have a contractor's license if completing installation.

3. Durable Medical Equipment (DME) providers must meet the standards to provide equipment under the Medicaid State Plan Program.

4. The service including assessment and travel fees must be prior authorized by the case manager.

2303.10C RECIPIENT RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2303.2C, the recipient must:

1. The recipient is responsible for notifying the provider and/or case manager of any issues or problems regarding the installation of any authorized equipment or modifications.

2. The recipient may not request any additional modifications that have not been authorized.

3. The recipient must notify their case manager once the modifications have been completed.

2303.11 HOME DELIVERED MEALS

Home delivered meals are the provision of meals to persons at risk of institutional care due to inadequate nutrition. Home delivered meals include the planning, purchase, preparation and delivery, or transportation costs of meals to a person's home.

## 2303.11A COVERAGE AND LIMITATIONS

~~Home delivered meals are the provision of meals to persons at risk of institutional care due to inadequate nutrition. Home delivered meals include the planning, purchase, preparation and delivery or transportation costs of meals to a person'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.

1. Home delivered meals must be prepared by an agency and be delivered to the recipient's home.

2. Meals provided by or in a child foster home, ~~adult family home,~~ community based residential facility, or adult day care are not included, nor is meal preparation.

3. The direct purchase of commercial meals, frozen meals, Ensure or other food or nutritional supplements is not allowed under this service category.

4. Home delivered meals are not intended to meet the full daily nutritional needs of a recipient~~.~~ and are not to exceed two meals per day.

5. More than one provider may be used to meet a recipient's assessed need; the case manager is responsible for ensuring the PA does not exceed two meals per day.

6. Case managers determine the need for this service based on ~~a Standardized Nutritional Profile, or~~the assessment, and by personal interviews with the recipient related to individual nutritional status.

7. All meals must comply with the Dietary Guidelines for Americans published by the Secretaries of the Department of Health and Human Services (DHHS) and the United States Department of Agriculture; and provide a minimum of 33 1/3% of the current daily Recommended Dietary Allowances (RDA) as established by the Food and Nutrition Board, National Research Council of the National Academy of Sciences.

8. Nutrition programs are encouraged to provide eligible participants meals which meet particular dietary needs arising from health or religious requirements or the ethnic background of recipients.

## 2303.11B ~~HOME DELIVERED MEALS~~ PROVIDER RESPONSIBILITIES

~~Meals are provided by governmental or community providers who meet the requirements of a meal provider under NRS 446 and who are enrolled with the DHCFP as a Medicaid Provider.~~

~~Pursuant to NRS 446: All nutrition sites which prepare meals must have a Food Service Establishment Permit as follows:~~

1. All Nutrition Programs must follow the Health and Safety Guidelines established for Food and Drink Establishments in NAC, Chapter 446 or local health code regulations.

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

3. Report all incidents of suspected food borne illness to the affected recipients and local health authority within 24 hours and to the ~~DHCFP District Office~~ case manager by the next business day.

~~All employees must pass State/FBI background checks.~~

~~Provide documentation of taxpayer identification number.~~

4. The service must be prior authorized by the case manager.

## 2303.11C RECIPIENT RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2303.2C, the recipient must:

1. The recipient must notify the case manager timely if they need to request any changes to their Home Delivered Meals service.

2. The recipient must notify their case manager if the authorized number of meals is not received.

## 2303.~~9~~12 PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS)

PERS is an electronic device which enables certain recipients at high risk of institutionalization to secure help in an emergency. The recipient may also wear a portable "help" button to allow for mobility. The system is programmed to signal a response center once the "help" button is activated.

## 2303.~~9~~12A COVERAGE AND LIMITATIONS

~~PERS is an electronic device which enables certain recipients at high risk of institutionalization to secure help in an emergency. The recipient may also wear a portable~~

~~"help" button to allow for mobility. The system is connected to a landline and programmed to signal a response center once the "help" button is activated.~~

1. PERS services are limited to those recipients who live alone in a private residence, or~~,~~ who are alone for significant parts of the day, in their residence, have no regular caregiver for extended periods of time and who would otherwise require extensive routine supervision or as identified to mitigate other safety risks and concerns. The recipient must be capable of using the device in an appropriate and proper manner.

2. The initial installation fee~~The waiver service pays for the device rental and funds ongoing monitoring on~~ and a monthly fee for ongoing monitoring are covered under this service~~basis~~.

3. The necessity for this type of emergency safety measure to prevent institutionalization will be identified in the assessment and included in the POC.

2303.~~9~~12B ~~PERS~~ PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2303.2B, PERS providers must:

~~The provider must provide documentation showing tax identification number.~~

1. ~~The provider is responsible for e~~Ensuring that the response center is staffed by trained professionals at all times~~.~~;

2. Complete ~~The provider is responsible for~~ any replacement or repair needs that may occur and provide monthly monitoring to ensure the device is working properly;~~.~~

3. ~~Providers of this service must utilize d~~Devices ~~that~~must meet Federal Communication Commission (FCC) standards, Underwriter's Laboratory (UL) standards or equivalent standards~~.~~; and

4. ~~Providers must i~~Inform recipients of any liability they ~~recipient~~ may incur as a result of the ~~recipient's~~ disposal or loss of provider property.

5. The~~is~~ service must be prior authorized by the case manager.

2303.~~9~~12C RECIPIENT RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2303.2C, the recipient must:

1. ~~The recipient is~~Be responsible ~~to utilize~~ for utilizing the leased PERS equipment with ~~care and~~care and caution and to notify the PERS provider when the equipment is no longer working.

2. ~~The recipient must r~~Return the equipment to the provider when it is no longer needed or utilized, or when the recipient terminates from the waiver program~~, or when the recipient moves out of state~~.

3. ~~The recipient may n~~Not dispose of or damage ~~throw away~~ the PERS equipment. This is leased equipment and belongs to the PERS provider.

## 2303.~~8~~13 SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES

Specialized medical equipment and supplies are those devices, controls, or appliances specified in the plan of care that enable recipients to increase their abilities to perform ADLs.

### 2303.~~8A~~13A COVERAGE AND LIMITATIONS

~~1. Specialized medical equipment and supplies are those devices, controls, or appliances specified in the plan of care that enable recipients to increase their abilities to perform ADLs.~~

~~2. This service also includes devices, controls, or applications which enable the recipient to perceive, control, or communicate with the environment in which they live; items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan.~~

~~3.~~1. Items reimbursed with waiver funds shall ~~be, in addition to any medical equipment and supplies, furnished under the State Plan and shall~~ exclude those items which are not of direct medical or remedial benefit to the recipient.

~~4.~~2. All items shall meet applicable standards of manufacture, design, and installation and where indicated, will be purchased from, and installed by authorized dealers.

3. This service includes:

   a. Devices, controls, or applications which enable the recipient to perceive, control,or communicate with the environment in which they live;

   b. Items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of such items; and

   c. Vehicle adaptations, assistive technology, and supplies.

4. Durable and non-durable medical equipment that has been exhausted, not available, or covered under the Medicaid State Plan, refer to MSM Chapter 1300 – DME Disposable Supplies and Supplements.

~~5. Vehicle Adaptations~~

~~All modifications and equipment must be purchased from authorized dealers, meet acceptable industry standards and have payment approved by the case manager.~~

~~6. Assistive Technology~~

~~All equipment must be purchased from authorized dealers when appropriate. Equipment must meet acceptable standards (e.g., Federal Communications Commission (FCC) and/or Underwriter's Laboratory requirements when applicable, and requirements under the Nevada Lemon Law NRS 597.600 to 597.680).~~

~~7. Supplies~~

~~Supplies must be purchased through a provider enrolled to provide such services under the existing state Medicaid plan or as otherwise approved by the DHCFP for services under this waiver.~~

2303.~~8~~13B ~~SPECIALIZED MEDICAL EQUIPMENT~~ PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2303.2B, providers must:

1. Meet the standards to provide equipment under the Medicaid State Plan Program; and

2. The service must be prior authorized by the case manager.

~~Providers must be licensed through the Nevada State Board of Pharmacy (BOP) as a Medical Device, Equipment, and Gases (MDEG) supplier, with the exception of a pharmacy that has a Nevada State Board of Pharmacy license and provides DME, Prosthetic Devices, Orthotic Devices and Disposable Medical Supplies (DMEPOS). Once licensed, providers must maintain compliance with all Nevada BOP licensing requirements.~~

2303.13C RECIPIENT RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2303.2C, the recipient must:

1. Notify the provider and/or case manager of any issues or problems regarding the installation or delivery of any authorized equipment or supplies.

2. Not request any additional specialized medical equipment or supplies that have not been authorized.

3. Notify their case manager once the specialized medical equipment or supplies have been received.

2303.14 ELECTRONIC VISIT VERIFICATION (EVV):

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 program. 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. Any errors within EVV submissions must be supported by offline documentation.

Agencies must ensure each personal care attendant has a unique identifier (National Provider Identification – NPI) associated with their worker profile in the EVV system.

1. 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 IVR purposes only);

        5. Other GPS-based devices as approved by DHCFP.

2. DATA AGGREGATOR OPTION:

a. All Personal Care Agencies that utilize a different EVV system (as approved by DHCFP) must comply with all documentation requirements of this chapter and must utilize the data aggregator to report encounter or claim data.

1. Appropriate forms must be approved by the DHCFP before use of the system to ensure all data requirements are being collected to meet the 21st Century Cures Act.

2. At a minimum, data uploads must be completed monthly into the data aggregator.

~~2303.9 PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS)~~

~~2303.9A COVERAGE AND LIMITATIONS~~

~~1. PERS is an electronic device which enables certain recipients at high risk of institutionalization to secure help in an emergency. The recipient may also wear a portable "help" button to allow for mobility. The system is connected to a landline and programmed to signal a response center once the "help" button is activated.~~

~~2.1. PERS services are limited to those recipients who live alone, who are alone for significant parts of the day, have no regular caregiver for extended periods of time and who would otherwise require extensive routine supervision.~~

~~3.1. The waiver service pays for the device rental and funds ongoing monitoring on a monthly basis.~~

~~2303.9B PERS PROVIDER RESPONSIBILITIES~~

~~1. The provider must provide documentation showing tax identification number.~~

~~2.1. The provider is responsible for ensuring that the response center is staffed by trained professionals at all times.~~

~~3.1. The provider is responsible for any replacement or repair needs that may occur.~~

~~4.1. Providers of this service must utilize devices that meet FCC standards, Underwriter's Laboratory standards or equivalent standards.~~

~~5.1. Providers must inform recipients of any liability the recipient may incur as a result of the recipient's disposal of provider property.~~

~~6.1.The service must be prior authorized.~~

~~2303.9C RECIPIENT RESPONSIBILITIES~~

~~1. The recipient is responsible to utilize the leased PERS equipment with care and caution and to notify the PERS provider when the equipment is no longer working.~~

~~2.1. The recipient must return the equipment to the provider when it is no longer needed or utilized, when the recipient terminates from the waiver program, or when the recipient moves out of state.~~

~~3.1. The recipient may not throw away the PERS equipment. This is leased equipment and belongs to the PERS provider.~~

## ~~2303.10 ASSISTED LIVING SERVICES~~

### ~~2303.10A COVERAGE AND LIMITATIONS~~

~~1. Assisted living services are all inclusive services furnished by the assisted living provider. Assisted living services are meant to provide all support services needed in the community and may include personal care, homemaker, chore, attendant care, meal preparation, companion, medication oversight (to the extent permitted under state law), transportation, diet and nutrition, orientation and mobility, community mobility/ transportation training, advocacy for related social services, health maintenance, active supervision, home and community safety training, therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility. Services provided by a third party must be coordinated with the assisted living facility. This service may include skilled or nursing care to the extent permitted by state law. Nursing and skilled therapy services are incidental, rather than integral to the provision of assisted living services. Payment is not to be made for 24 hour skilled care. If a recipient chooses assisted living services, other individual waiver services may not be provided, except case management services.~~

~~2.1. The service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way promoting maximum dignity and independence, and to provide supervision, safety and security.~~

~~3.1. Assisted living providers are expected to furnish a full array of services except when another Federal program is required to provide the service. Other individuals or agencies may also furnish care directly, or under arrangement with the assisted living provider, but the care provided by other entities supplements that provided by the assisted living provider and does not supplant it.~~

~~4.1. Federal Financial Participation (FFP) is not available for room and board, items of comfort, or the cost of facility maintenance, upkeep and improvement.~~

### ~~2303.10B ASSISTED LIVING PROVIDER RESPONSIBILITIES~~

~~1. The assisted living environment must evidence a setting providing:~~

~~a. living units that are separate and distinct from each other;~~

~~b.a. a central dining room, living room or parlor and common activity center(s) except in the case of individual apartments;~~

~~c.a. 24 hour on-site response staff.~~

~~2.1. All persons performing services to recipients from this category must have criminal history clearances obtained from the FBI through the submission of fingerprints to the FBI. In addition, provider agencies are required to conduct routine screenings on all applicants who will perform services to recipients to ensure the health and welfare of recipients and to make every effort possible to prevent recipient abuse. Reference Section 2303.3B2.d.~~

~~3.1. Providers must arrange training in personal hygiene needs and techniques for assisting with ADLs such as bathing, dressing, grooming, skin care, transfer, ambulation, exercise, feeding, use of adaptive aids and equipment, identifying emergency situations and how to act accordingly.~~

~~4.1. Must have current CPR certification which may be obtained outside the agency prior to initiation of services to a Medicaid recipient.~~

~~5.1. Caregiver Supervisors will:~~

~~a. possess at least one year of supervisory experience and a minimum of two years experience working with adults with physical disabilities, including traumatic brain injury.~~

~~b.a. demonstrate competence in designing and implementing strategies for life skills training and independent living.~~

~~c.a. possess a bachelor's degree in a human service field preferably, or education above the high school level combined with the experience noted in paragraph (a) above.~~

~~Supporting Qualifications of the Caregiver Supervisor are:~~

~~1. experience in collecting, monitoring, and analyzing service provision; ability to identify solutions and satisfy staff/resident schedules for site operations.~~

~~2.1. ability to interpret professional reports.~~

~~3.1. knowledge of life skills training, personal assistance services, disabled advocacy groups, accessible housing, and long-term care alternatives for adults with physical disabilities and/or traumatic brain injuries.~~

~~4.1. dependable, possess strong organization skills and have the ability to work independent of constant supervision.~~

~~6.1. Assisted Living Attendants~~

~~Assisted living attendants shall provide personal care services, community integration, independent living assistance, and supervisory care to assist the recipient in following the POC. Assisted living attendants shall possess:~~

~~a. a high school diploma or GED.~~

~~b.a. some post-secondary educational experience is desired.~~

~~c.a. a minimum of two positive, verifiable employment experiences.~~

~~d.a. two years of related experience is desired.~~

~~e.a. job experience demonstrating the ability to teach, work independently without constant supervision, and demonstrating regard and respect for recipients and co-workers.~~

~~f.a. verbal and written communication skills.~~

~~g.a. the ability to handle many details at the same time.~~
~~h.a. the ability to follow-through with designated tasks.~~

~~i.a. knowledge in the philosophy and techniques for independent living for people with disabilities.~~

~~j.a. if the attendant is providing attendant care services, that include skilled services, the attendant must meet the requirements of NRS 629.091.~~

~~k.a. a current CPR certificate.~~

~~7.1. Supporting Qualifications of the assisted living attendant are:~~

~~a. dependability, able to work with minimal supervision;~~

~~b.a. demonstrates problem solving ability;~~

~~c.a. the ability to perform the functional tasks of the job.~~

~~8.1. The service must be prior authorized.~~

## ~~2303.11 HOME DELIVERED MEALS~~

~~2303.11A COVERAGE AND LIMITATIONS~~

~~Home delivered meals are the provision of meals to persons at risk of institutional care due to inadequate nutrition. Home delivered meals include the planning, purchase, preparation and delivery or transportation costs of meals to a person'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.~~

~~1. Home delivered meals must be prepared by an agency and be delivered to the recipient's home.~~

~~2.1. Meals provided by or in a child foster home, adult family home, community based residential facility or adult day care are not included, nor is meal preparation.~~

~~3.1. The direct purchase of commercial meals, frozen meals, Ensure or other food or nutritional supplements is not allowed under this service category.~~

~~4.1. Home delivered meals are not intended to meet the full daily nutritional needs of a recipient. More than one provider may be used to meet a recipient's need.~~

~~5.1. Case managers determine the need for this service based on a Standardized Nutritional Profile, or assessment, and by personal interviews with the recipient related to individual nutritional status.~~

~~6.1. All meals must comply with the Dietary Guidelines for Americans published by the Secretaries of the Department of Health and Human Services (DHHS) and the United States Department of Agriculture; and provide a minimum of 33 1/3% of the current daily Recommended Dietary Allowances (RDA) as established by the Food and Nutrition Board, National Research Council of the National Academy of Sciences.~~

~~7.1. Nutrition programs are encouraged to provide eligible participants meals which meet particular dietary needs arising from health or religious requirements or the ethnic background of recipients.~~

~~2303.11B HOME DELIVERED MEALS PROVIDER RESPONSIBILITIES~~

~~1. Meals are provided by governmental or community providers who meet the requirements of a meal provider under NRS 446 and who are enrolled with the DHCFP as a Medicaid Provider.~~

~~2.1. Pursuant to NRS 446: All nutrition sites which prepare meals must have a Food Service Establishment Permit as follows:~~

~~1. All Nutrition Programs must follow the Health and Safety Guidelines established for Food and Drink Establishments in NAC, Chapter 446 or local health code regulations.~~

~~2.1. All kitchen staff must hold a valid health certificate if required by local health ordinances.~~

~~3.1. Report all incidents of suspected food borne illness to the affected recipients and local health authority within 24 hours and to the DHCFP District Office case manager by the next business day.~~

~~3. All employees must pass State/FBI background checks.~~

~~4. Provide documentation of taxpayer identification number.~~

~~5.4. The service must be prior authorized.~~

## ~~2303.12 ATTENDANT CARE~~

### ~~2303.12A COVERAGE AND LIMITATIONS~~

~~Extended State plan personal care attendant service may include assistance with eating, bathing, dressing, personal hygiene, ADLs, shopping, laundry, meal preparation and accompanying the recipient to appointments as necessary to enable the individual to remain in the community. The service may include hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically disabled individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. This service may include skilled services to the extent permitted by State law. This service may include an extension of task completion time allowed under the state plan with documented medical necessity.~~

~~1. Where possible and preferred by the recipient, he/she will direct his/her own service through an Intermediary Services Organization (ISO). Refer to MSM Chapter 2600. When the recipient recruits and selects a caregiver, the individual is referred to the ISO for hire. The recipient may also terminate the assistant. When utilizing this option, the recipient will work with his/her case manager to identify an appropriate back up plan. If this option is not used, the recipient will choose a provider agency that will otherwise recruit, screen, schedule assistants, provide backup and assurance of emergency assistance.~~

~~2.1. Extended personal care attendant services in the recipient's plan of care may include assistance with:~~

~~a. eating;~~

~~b.a. bathing;~~

~~e.a. dressing;~~

~~d.a. personal hygiene;~~

~~e.a. ADLs;~~

~~f.a. hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically disabled individual. Supportive services are those which substitute for the absence, loss, diminution or impairment of a physical or cognitive function.~~

~~3.1. Flexibility of Services~~

~~Flexibility of service delivery which does not alter medical necessity may occur within a single week period without an additional authorization. Reference 2303.3B.1.e of this chapter.~~

## ~~2303.12B ATTENDANT CARE PROVIDER RESPONSIBILITIES~~

~~In addition to the following requirements listed, reference Section 2303.3B of this Chapter regarding Individual Provider Responsibilities.~~

~~1. Personal care attendants may be members of the individual's family. However, payment will not be made for services furnished by legally responsible individuals.~~

~~2.1. When the provision of services includes an unskilled provider completing skilled care, qualifications and requirements must be followed as in NRS 629.091, and MSM Chapter 2600.~~

~~3.1. Providers must demonstrate the ability to:~~

~~a. perform the care tasks as prescribed;~~

~~b.a. identify emergency situations and to act accordingly, including CPR certification which may be obtained outside the agency;~~

~~c.a. maintain confidentiality in regard to the details of case circumstances; and~~

~~d.a. document in writing the services provided.~~

~~4.3. Provider Agencies must arrange training in:~~

~~a. procedures for arranging backup when not available, agency contact person(s), and other information as appropriate. (Note: This material may be provided separate from a training program as part of the provider's orientation to the agency.)~~

b.a. personal hygiene needs and techniques for assisting with ADLs, such as bathing, grooming, skin care, transfer, ambulation, exercise, feeding, dressing, and use of adaptive aids and equipment.

c.a. home making and household care, including good nutrition, special diets, meal planning and preparation, essential shopping, housekeeping techniques and maintenance of a clean, safe and healthy environment.

5. Service must be prior authorized and documented in an approved EVV System.

4.3. Provider is responsible to ensure that EVV requirements and expectations are met, including the documentation of all services in approved EVV System.

2303.13 PROVIDER ENROLLMENT/TERMINATION

All providers must comply with all the DHCFP provider enrollment requirements, provider responsibilities/qualifications, and the DHCFP provider agreement limitations. Provider non-compliance with all or any of these stipulations may result in Nevada Medicaid's decision to exercise its right to terminate the provider's contract. Refer to MSM Chapter 100 for general enrollment policies.

2303.14 INTAKE PROCEDURES

The DHCFP developed procedures to ensure fair and adequate access to services covered under the HCBW for Persons with Physical Disabilities.

2303.14A COVERAGE AND LIMITATIONS

1. Slot Provisions

a. The allocation of waiver slots is maintained statewide based on priority and referral date. Slots are allocated by priority based on the earliest referral date.

b. Recipients must be terminated from the waiver when they move out of state, fail to cooperate with program requirements or request termination; their slot may be given to the next person on the waitlist.

c. When a recipient is placed in an NF or hospital, they must be sent a NOD terminating them from the waiver 45 days from admit date. Their waiver slot must be held for 90 days from the NOD date. They may be placed back in that slot if they are released within 90 days of the NOD date and request reinstatement. They must continue to meet program eligibility criteria. After 90 days, their slot may be given to the next individual on the waitlist.

~~2. Referral Pre-Screening~~

~~a. A referral or inquiry for the waiver may be made by the potential applicant or by another party on behalf of the potential applicant by contacting the local DHCFP District Office. The DHCFP District Office staff will discuss waiver services, including the eligibility requirements, with the referring party or potential applicant.~~

~~b. If the case manager determines the applicant does not appear to meet the waiver criteria, the individual may proceed with the application process if they choose to. Once the application is denied, they will receive a NOD which includes the right to a fair hearing. The case manager will provide referrals to other community resources.~~

~~c. If the case manager determines the applicant does appear to meet waiver criteria, a face-to-face home visit is scheduled to conduct an LOC screening and medical records are obtained for a disability determination.~~

~~NOTE: If the applicant does not meet LOC, they will receive a NOD which includes the right to a fair hearing.~~

~~3. Placement on the Wait List~~

~~a. All applicants who meet program criteria must be placed on the statewide waitlist by priority and referral date. The following must be completed prior to placement on the waitlist.~~

~~1. The applicant must meet LOC criteria for placement in an NF.~~

~~2. The applicant must require at least one ongoing waiver service.~~

~~3. The applicant must be certified as physically disabled by Medicaid's Central Office Disability Determination Team.~~

~~4. Applicants must be sent a NOD indicating "no slot available."~~

~~4. Waiver Slot Allocation~~

~~Once a slot for the waiver is available, the applicant will be assigned a waiver slot and be processed for the waiver.~~

~~a. Intake:~~

~~1. The DHCFP District Office staff will schedule a face-to-face home visit with the recipient to complete the full waiver assessment.~~

~~2. The case manager will obtain all applicable forms, including the Authorization for Release of Information Form.~~

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

~~The case manager will provide an application to apply for Medicaid benefits through the DWSS. The recipient is responsible for completing the application and submitting all requested information to the DWSS. The case manager will assist upon request.~~

~~3. The applicant is given the right to choose waiver services in lieu of placement in an NF. When the applicant or designated legal representative prefers placement in an NF, the case manager will assist the applicant in arranging for facility placement.~~

~~4. The applicant is given the right to request a hearing if not given a choice between HCBS and NF placement.~~

~~5. When the applicant is approved for the waiver:~~

~~a. A written POC is developed in conjunction with the recipient by the DHCFP District Office case manager for each recipient under the waiver. The POC is based on the assessment of the recipient's health and welfare needs.~~

~~b. The recipient or representative is included in the development of the POC.~~

~~c. The POC is subject to the approval of the DHCFP's Central Office Waiver Unit.~~

~~d. Recipients are given free choice of all qualified Medicaid providers for each Medicaid covered service included in the POC. Current POC information as it relates to the services provided must be given to all service providers.~~

~~6. All forms must be complete with signature and dates when required.~~

~~7. If an applicant is denied waiver services, the case manager sends the NOD.~~

~~5. Effective Date for Waiver Services~~

~~The effective date for waiver services approval is the completion date of all the intake forms and the Medicaid determination date made by the DWSS, whichever is later. When the recipient resides in an institution, the effective date cannot be prior to the date of discharge from the institution.~~

~~6. Waiver Costs~~

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

## 2303.15 DHCFP LTSS INITIAL REVIEW

Once the applicant has been approved for the waiver, the DHCFP LTSS Unit will review all initial eligibility packets for completeness to ensure waiver requirements are being met. The eligibility packet for review must include:

1. The NF LOC screening to verify the applicant meets the NF LOC criteria;
2. At least one waiver service need identified;
3. The SOC complete with signature and dates; and
4. The HCBS Acknowledgement Form is complete including initials, signature, and date.

NOTE: Electronic signatures are acceptable pursuant to NRS 719.350 "Acceptance and distribution of electronic records by governmental agencies" on forms that require a signature.

## 2303.16 WAIVER COSTS

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

## 2303.17 QUALITY ASSURANCE WAIVER ~~ANNUAL~~ REVIEW

~~The State has in place a formal system in which an annual review is conducted to assure the health and welfare of the recipients served on the waiver, the recipient satisfaction with the waiver, and assurance of the cost effectiveness of these services.~~

The state ~~will~~ conducts an annual review of active waiver participants.~~; and~~ CMS has designated waiver assurances and sub-assurances that states must include as part of an overall quality improvement strategy. The annual review is conducted using the state specified performance measures identified in the approved PD Waiver to evaluate operation.

~~provide CMS with information on the impact of the waiver. This includes the type, amount and cost of services provided under the waiver and provided under the State Plan and the health and welfare of the recipients served on the waiver.~~

~~assure financial accountability for funds expended for HCBS.~~

~~evaluate all provider standards are continuously met and plans of care are periodically reviewed to assure services furnished are consistent with the identified needs of the recipients.~~

~~evaluate the recipients' satisfaction with the waiver program.~~

~~ensure health and welfare of all recipients.~~

~~2303.17A PROVIDER RESPONSIBILITIES~~

Case management and direct waiver service ~~P~~providers must cooperate with ADSD Operations and ~~the~~ DHCFP's ~~annual~~ review process.

2303.~~2B~~18 MEDICAID EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)

The children made eligible for Medicaid through their enrollment in the HCB~~W~~S ~~for Persons with Physical Disabilities~~ PD Waiver receive all medically necessary Medicaid covered services available under EPSDT. A child's enrollment in the waiver will not be used to deny, delay, or limit access to medically necessary service(s) required to be available to Medicaid-eligible children under federal EPSDT rules. The waiver service package is a supplement to EPSDT services.

2303.1~~3~~9 PROVIDER ENROLLMENT~~/TERMINATION~~

All providers must maintain a Medicaid services provider agreement and comply with the criteria set forth in the Nevada MSM Chapter 100 and Chapter 2300. ~~all the DHCFP provider enrollment requirements,~~ Provider Enrollment checklists and forms can be found on the Fiscal Agent's website https://www.medicaid.nv.gov. ~~provider responsibilities/qualifications, and the DHCFP provider agreement limitations. Provider noncompliance with all or any of these stipulations may result in Nevada Medicaid's decision to exercise its right to terminate the provider's contract. Refer to MSM Chapter 100 for general enrollment policies.~~

2303.~~15~~20 BILLING PROCEDURES

~~The~~ DHCFP ~~must~~ assure~~s~~ ~~CMS~~ that all claims for payment of waiver services are made only when a~~n~~ recipient ~~individual~~ is Medicaid eligible, when the service(s) are identified on the approved POC, and ~~if~~ the service(s) ~~has~~ have been prior authorized.

Refer to the Fiscal Agent's website https://www.medicaid.nv.gov for the Provider Billing Guide Manual.

~~2303.15A COVERAGE AND LIMITATIONS~~

~~Provider Type 58, HCBW for Persons with Physical Disabilities, must complete the CMS 1500 for payment of waiver services. Incomplete or inaccurate claims are returned to the provider by the DHCFP's fiscal agent. If the wrong form is submitted it is also returned to the provider by the DHCFP's fiscal agent.~~

~~2303.15B PROVIDER RESPONSIBILITY~~

~~Providers must submit claims to the DHCFP's QIO-like vendor.~~

~~Providers may also refer to the DHCFP's website for a complete list of codes/modifiers billable under Provider Type 58 (select "Rates" from the main menu, then click on Provider Type 58 – HCBW for Persons with Physical Disabilities).~~

2303.~~16~~21 ADVANCE DIRECTIVES

Section 1902(w) of the Social Security Act requires licensed providers ~~agencies~~ to ~~providing~~ provide ~~personal care aide services to give~~their ~~clients'~~ recipients with information regarding ~~each individual's~~ their decision-making rights about health care, declarations (living wills) and durable powers of attorney for health care decisions. Refer to MSM Chapter 100 for further information.

The case manager must provide information on Advance Directives to each recipient and/or designated representative/LRI during the initial assessment and annually thereafter. The signed Acknowledgement form is kept in each recipient's file. Whether a recipient chooses to write their own Advance Directive or complete an Advance Directive form in full is the individual choice of each recipient and/or designated representative/LRI.

~~2303.17 ANNUAL REVIEW~~

~~The State has in place a formal system in which an annual review is conducted to assure the health and welfare of the recipients served on the waiver, the recipient satisfaction with the waiver, and assurance of the cost effectiveness of these services.~~

~~The state will conduct an annual review; and~~

~~1. provide CMS with information on the impact of the waiver. This includes the type, amount and cost of services provided under the waiver and provided under the State Plan and the health and welfare of the recipients served on the waiver.~~

~~2.1. assure financial accountability for funds expended for HCBS.~~

~~3.1. evaluate all provider standards are continuously met and plans of care are periodically reviewed to assure services furnished are consistent with the identified needs of the recipients.~~

~~4.1. evaluate the recipients' satisfaction with the waiver program.~~

~~5.1. ensure health and welfare of all recipients.~~

~~2303.17A PROVIDER RESPONSIBILITIES~~

~~Providers must cooperate with the DHCFP's annual review process.~~

## 2304 HEARINGS REQUESTS DUE TO ADVERSE ACTIONS

An adverse action refers to denials, terminations, reductions, or suspensions of the applicant's/recipient's request for services or an applicant's/recipient's eligibility determination. DHCFP must grant an opportunity for a hearing to an applicant/recipient/designated representative in the event an adverse action is taken by DHCFP.

### 2304.1~~A~~ SUSPENDED WAIVER SERVICES

~~1.~~ When a ~~R~~recipient~~s~~ is institutionalized less than 60 days, their waiver services must be suspended ~~when they are admitted to a hospital or Nursing Facility (NF)~~.

1. Upon receipt of the suspension notification from the case management provider, DHCFP LTSS will issue a suspension NOD to the recipient.

2. Waiver services will not be paid for the days that a recipient's eligibility is in suspension.

~~2.~~3. If the recipient continues to be institutionalized for 45 days, on the 46th day, the case manager will request DHCFP LTSS to send a termination NOD to the recipient indicating termination from the waiver on the 61st day from the admission date.~~has not been removed from suspended status 45 days from the admit date, the case must be closed. A Notice of Decision (NOD) must be sent identifying the 60th day of the admit date as the effective date for closure.~~

### 2304.~~1B~~2 RELEASE FROM SUSPENDED WAIVER SERVICES

When a recipient ~~is~~ has been released from ~~the hospital~~an institution, ~~an NF or other institutional setting, within~~ before the 60th day~~s of~~ from the admit date, the case manager must do the following within five ~~working~~ business days of the recipient's discharge:

1. ~~c~~Complete a reassessment~~new Level of Care (LOC),~~ if there has been a significant change in the recipient's condition or status;

2. ~~c~~Complete a new ~~Plan of Care (~~POC~~)~~ if there has been a change in waiver services. ~~(medical, social, or waiver). When~~If a change in services is expected to ~~resolve~~ be resolved in less than 30 days a new POC is not necessary. Documentation of the temporary change must be noted in the case manager's narrative~~case record~~; and

3. contact the service provider(s) to reestablish services.

### 2304.~~1C~~3 DENIAL OF WAIVER ELIGIBILITY~~SERVICES~~

Basis of denial ~~Reasons to deny applicant request~~ for waiver eligibility~~services~~:

1. The service(s) is/are not substantiated as medically necessary. Contact your Medicaid provider as there may be additional documentation to submit to demonstrate a medical necessity. ~~The applicant does not meet physical disability criteria as determined by the DHCFP's physician consultant.~~

2. The applicant does not meet the LOC criteria for ~~an~~ NF placement.

3. The applicant has withdrawn their request for waiver services.

4. The applicant fails to cooperate with the ~~DHCFP C~~case ~~M~~manager ~~or Home and Community Based Services (HCBS) providers~~ in establishing program eligibility ~~and/~~or ~~implementing the POC, implementing~~ waiver services ~~or verifying eligibility for waiver services.~~ (~~T~~the applicant/recipient's ~~and/recipient's~~ or ~~the recipient's authorized~~ designated representative/LRI's signature is necessary for all required paperwork).

5. The applicant's support system is not adequate to provide a safe environment during the time ~~when home and community based~~waiver services are not being provided.

6. The ~~DHCFP~~ case manager has lost contact with the applicant.

7. The applicant/recipient fails to show a need for ~~Home and Community Based~~ongoing ~~W~~waiver ~~(HCBW)~~ services.

8. The applicant would not require NF placement within 30 days or less if ~~HCBS~~ waiver services were not available.

9. The applicant has moved out of the state.

10. Another agency or program will provide the services.

11. ADSD~~The DHCFP District Office~~ has filled the number of positions (slots) allocated ~~to the HCBW for Persons with Physical Disabilities.~~ The applicant will be approved for the waiver waitlist and will be contacted when a slot is available.

    Wait List Priority:

    Level 1: Applicants previously in a hospital or NF and who have been discharged to the community within six months and have a significant change in support system and are in a crisis situation;

    Level 2: Applicants who have a significant change in support system and/or in a crisis situation and require at least maximum assistance in a combination of four or more of the following ADLs: eating, bathing, toileting, transfers, and mobility;

Level 3: Applicants who have a significant change in support system and/or in a crisis situation and require assistance with a combination of five or more of the following ADLs as identified on the LOC screening: medication administration, special needs, bed mobility, transferring, dressing, eating and feeding, hygiene, bathing, toileting, and locomotion;

Level 4: Applicants who do not meet the criteria for priority levels 1-3.

~~12. The applicant has failed to provide adequate medical documentation for a disability determination within 45 days of the request.~~

~~13. The applicant has reached their annual limit for Environmental Adaptations.~~

~~14. The requested adaption, equipment or supply is not medically necessary to prevent institutionalization.~~

~~15. The landlord has not approved requested adaption or modification.~~

~~16. The recipient's needs can be met by a legally responsible individual.~~

12. There are no enrolled Medicaid providers or facilities in the applicant's area.

13. The applicant is in an institution (e.g. hospital, nursing facility, correctional facility, ICF/IID) and discharge within 60 calendar days is not anticipated.

14. The applicant has chosen a provider or facility that is not an enrolled or qualified Medicaid provider. Note: The case manager should provide a list of Medicaid providers to the applicant. The case manager will inform the provider that all entities providing services must be enrolled as a Medicaid provider and facilitate contact information to the DHCFP's Fiscal Agent.

When ~~an~~ the application for waiver services is denied, the case manager will send a NOD request to DHCFP LTSS Unit. The DHCFP LTSS Unit sends a NOD to the applicant/recipient informing them of ~~sends a NOD indicating~~ the reason for denial.

## 2304.4 REDUCTION OR DENIAL OF DIRECT WAIVER SERVICES

Basis of reduction or denial of direct waiver services:

1. The recipient no longer requires the waiver service, number of service hours, or level of service which was previously authorized.

2. The recipient has requested a reduction of services, or a specific waiver service to be discontinued.

3. Another service will be substituted for the existing service, or there is a reduction or termination of a specific waiver service.

4. The recipient has reached or will exceed their annual amount limit for Environmental Adaptations and/or Specialized Medical Equipment.

5. The requested adaptation for the recipient, equipment or supply is not medically necessary to prevent institutionalization.

6. The landlord has not approved requested adaption or modification for the recipient.

7. The recipient does not demonstrate a need or have the capacity/ability for the requested waiver services.

NOTE: A reduction includes when a specific waiver service's hours are reduced to zero.

When there is a reduction of waiver services, the case manager will identify the reason for the reduction and what the service will be reduced to and request the DHCFP LTSS Unit to send a NOD. DHCFP LTSS will issue a reduction NOD indicating the reason and the date of action which is at least 13 calendar days from the notice date. Refer to MSM Chapter 3100 Hearings, for specific instructions regarding notification and recipient hearings.

When the request for a direct waiver service(s) is denied, the case manager will send a NOD request to the DHCFP LTSS Unit. The DHCFP LTSS Unit sends a NOD to the applicant/recipient informing them of the reason for denial.

## 2304.~~1D~~5 TERMINATION OF WAIVER PROGRAM ELIGIBILITY~~SERVICES~~

Reasons to terminate waiver program eligibility~~a recipient from the waiver or to terminate the recipient from the waiver wait list~~:

~~1. The recipient has failed to pay his/her patient liability.~~

~~2. The recipient no longer meets the physical disability criteria as determined by the DHCFP's physician consultant.~~

~~3.~~1. The recipient no longer meets the LOC criteria for NF placement.

~~4.~~2. The recipient and/or designated representative/LRI ~~has~~ have requested termination of waiver services.

~~5.~~3. The recipient and/or designated representative/LRI has failed to cooperate with the ~~DHCFP c~~Case ~~m~~Manager or HCBS waiver service provider(s) ~~in establishing and/or implementing the POC, implementing waiver services, or verifying eligibility for waiver services. (The~~

~~recipient's or the recipient's authorized representative's signature is necessary on all required paperwork).~~

~~6.~~4. The recipient fails to show a continued need for ~~HCBW~~ HCBS waiver services.

~~7.~~5. The recipient no longer requires NF placement within 30 calendar days if HCBS were not available.

~~8.~~6. The recipient has moved out of state.

~~9.~~7. The recipient and/or designated representative/LRI has participated in activities designed to defraud the waiver program.~~submitted fraudulent documentation on Attendant Care provider time sheets and/or forms~~.

~~10.~~8. Another agency or program ~~will provide~~ is providing duplicative ~~the~~ services.

~~11.~~9. The recipient has been, or is expected to be, institutionalized over 60 days (in a hospital, NF, intermediate facility for persons with mental retardation or incarcerated).

~~12.~~10. The ~~DHCFP~~ case manager has lost contact with the recipient.

~~13. The recipient's needs can be met by a legally responsible individual.~~

11. Death of the recipient.

12. The recipient's support system is not adequate to provide a safe environment during the time when HCBS waiver services are not being provided.

13. HCBS waiver services are not adequate to ensure the health, welfare, and safety of the recipient.

14. The recipient has failed to cooperate with the case manager or HCBS waiver service provider(s) in establishing and/or implementing the POC, implementing waiver services or verifying eligibility for waiver services (the recipient and/or designated representative/LRI's signature is necessary on all required paperwork.).

When a recipient is terminated from the waiver program, the ~~c~~Case ~~m~~Manager will request the DHCFP LTSS Unit to send~~s~~ a NOD. DHCFP LTSS will issue a termination NOD indicating the reason and the date of action which is~~for termination~~ at least 13 calendar days from the notice date. ~~The NOD must be mailed to the recipient at least 13 calendar days before the Date of Action~~. Refer to MSM Chapter 3100 - Hearings for specific instructions regarding ~~exceptions to the~~ advance notification and recipient hearings.~~notice~~.

~~2304.1E REDUCTION OF WAIVER SERVICES~~

~~Reasons to reduce waiver services:~~

~~1. The recipient no longer needs the number of service hours authorized.~~

~~2. The recipient no longer needs the service previously authorized.~~

~~3. The recipient has requested the reduction of services.~~

~~4. The recipient's ability to perform Activities of Daily Living (ADLs) has improved.~~

~~5. Another agency or program will provide the service.~~

~~6. The recipient fails to cooperate with the waiver service provider.~~

~~7. The recipient's needs can be met by a legally responsible individual.~~

~~When there is a reduction of waiver services the case manager will send a NOD indicating the reason for the reduction. The NOD must be mailed to the recipient at least 13 calendar days before the Date of Action.~~

## ~~2304.2~~ 2304.6REAUTHORIZATION WITHIN 90 DAYS OF WAIVER TERMINATION

~~A.~~ If a recipient is placed in a~~n~~ NF, ~~or~~ hospital, or is incarcerated and waiver eligibility ~~services have~~ has been terminated, the recipient may request to be ~~reinstatement~~ reinstated within 90 days from the date of action on the NOD.~~of the notice date. The case manager must complete the following:~~

### 2304.6A COVERAGE AND LIMITATIONS

1. The waiver slot must be held for 90 days from the date of action listed on the NOD.

2. The recipient may request to be placed back on the waiver if:

   ~~1.~~a. They still meet~~A new~~ LOC; and

   ~~2.~~b. They are released/discharged within 90 days.~~A new Social Health Assessment;~~.

   ~~3. The new Statement of Understanding; and~~

   ~~4. The new POC.~~

~~B.~~3. If ~~90~~ 91calendar days ~~from the notice date~~ has elapsed, from the date of action on the NOD, the slot is allocated to the next person on the waitlist. ~~An individual who requests reinstatement after 90 days from the notice date must be processed as a new referral.~~

### 2304.6B PROVIDER RESPONSIBILITIES

The last known case management provider is responsible for resuming case management responsibilities for the recipient within three business days, to include the following:

1. Contact DWSS via the NMO-3010 to reinstate eligibility;

2. Contact DHCFP LTSS Unit via the NMO-3010 to reinstate the waiver benefit line;

3. Contact ADSD Operations Agency to notify of the reinstatement of waiver slot placement; and

4. Notify all direct waiver service providers of waiver reinstatement.

If the case manager determines that there has been a significant change in the recipient's condition as appropriate, refer to MSM section 2303.4A.3.e. for requirements.

2304.6C RECIPIENT RESPONSIBILITIES

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

2. If the recipient is discharged after the 90th day from the date of action on the NOD, they must reapply for waiver services.

230~~4.35~~ APPEALS AND HEARINGS

Refer to MSM Chapter 3100 for specific instructions regarding notice and hearing procedures. Recipients are informed of their rights to a fair hearing at the initial face-to-face visit and annually thereafter when they are given the Recipient Rights form.~~participant hearings~~.