Medicaid Services Manual
Transmittal Letter

May 27, 2025

To: Custodians of Medicaid Services Manual

From: Casey Angres
Chief of Division Compliance

Subject: Medicaid Services Manual Changes
Chapter 2400 – Structured Family Caregiving Waiver

Background And Explanation

The Division of Health Care Financing and Policy (DHCFP) is proposing a new Medicaid Services Manual (MSM) Chapter 2400 - Home and Community-Based Services (HCBS) Waiver for Structured Family Caregiving (SFCG), to comply with Assembly Bill 208 that was passed during the Nevada 82nd Legislative session and was approved by the Centers for Medicare and Medicaid Services (CMS) on December 19, 2024, with an effective date of January 1, 2025.

This waiver was developed to assist individuals with dementia or related conditions and provide access to both State Plan services as well as certain extended Medicaid covered services. Services included in this waiver are Case Management, Respite and SFCG. Nevada acknowledges that people who are suffering from dementia or related conditions can lead satisfying and productive lives when they are provided with the services and supports in the community.

Entities Financially Affected: HCBS Waiver for SFCG - Provider Type (PT) 95.

Financial Impact on Local Government: Unknown at this time.

These changes are effective June 1, 2025.

Material Transmitted	Material Superseded
MTL OL Chapter 2400 – Structured Family Caregiving Waiver	MTL NEW Chapter 2400 – Structured Family Caregiving Waiver

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2400	**Introduction**	Added “Introduction’’ section.
2401	**Authority**	Added “Authority’’ section.
2402	**Reserved**	Added “Reserved’’ section.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2403	**Policy**	Added “Policy’’ section.
2403.1	**Waiver Eligibility Criteria**	Added “Waiver Eligibility Criteria’’ section.
2403.1A	**Coverage and Limitations**	Added “Coverage and Limitations’’ section.
2403.1B	**Applicant/Recipient Responsibilities**	Added “Applicant/Recipient Responsibilities’’ section.
2403.2	**Waiver Services**	Added “Waiver Services’’ section.
2403.2A	**Coverage and Limitations**	Added “Coverage and Limitations’’ section.
2403.2B	**Provider Responsibilities**	Added “Provider Responsibilities’’ section.
2403.2C	**Recipient Responsibilities**	Added “Recipient Responsibilities’’ section.
2403.3	**Intake Activities**	Added “Intake Activities’’ section.
2403.3A	**Coverage and Limitations**	Added “Coverage Activities’’ section.
2403.4	**Case Management**	Added “Case Management’’ section.
2403.4A	**Coverage and Limitations**	Added “Coverage and Limitations’’ section.
2403.4B	**Provider Responsibilities**	Added “Provider Responsibilities’’ section.
2403.5	**Respite Care**	Added “Respite Care’’ section.
2403.5A	**Coverage and Limitations**	Added “Coverage and Limitations’’ section.
2403.5B	**Provider Responsibilities**	Added “Provider Responsibilities’’ section.
2403.5C	**Recipient Responsibilities**	Added “Recipient Responsibilities’’ section.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2403.6	**DHCFP LTSS Initial Review**	Added "DHCFP LTSS Initial Review'' section.
2403.7	**Waiver Costs**	Added "Waiver Costs'' section.
2403.8	**Quality Assurance Waiver Review**	Added "Quality Assurance Waiver Review'' section.
2403.9	**Provider Enrollment**	Added "Provider Enrollment'' section.
2403.10	**Billing Procedures**	Added "Billing Procedures'' section.
2403.11	**Advance Directives**	Added "Advance Directives'' section.
2404	**Hearings Request Due to Adverse Actions**	Added "Hearings Request Due to Adverse Actions'' section.
2404.1	**Suspended Waiver Services**	Added "Suspended Waiver Services'' section.
2404.2	**Release From Suspended Waiver Services**	Added "Release From Suspended Waiver Services'' section.
2404.3	**Denial of Waiver Eligibility**	Added "Denial of Waiver Eligibility'' section.
2404.4	**Reduction or Denial of Direct Waiver Services**	Added "Reduction or Denial of Direct Waiver Services'' section.
2404.5	**Termination of Waiver Program Eligibility**	Added "Termination of Waiver Program Eligibility'' section.
2404.6	**Reauthorization Within 90 Days of Waiver Termination**	Added "Reauthorization Within 90 Days of Waiver Termination'' section.
2404.6A	**Coverage and Limitations**	Added "Coverage and Limitations'' section.
2404.6B	**Provider Responsibilities**	Added "Provider Responsibilities'' section.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2404.6C	**Recipient Responsibilities**	Added “Recipient Responsibilities’’ section.
2405	**Appeals and Hearings**	Added “Appeals and Hearings’’ section.

2400 INTRODUCTION

The Home and Community-Based Services (HCBS) Waiver for Structured Family Caregiving (SFCG) recognizes that many individuals are at risk of being placed in hospitals or Nursing Facilities (NF) 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 SFCG Waiver is an optional service approved by the Centers for Medicare and Medicaid Services (CMS), which authorizes the Division of Health Care Financing and Policy (DHCFP) with the flexibility to design this waiver and select the mix of waiver services that best meet the goals of the program. This waiver allows the provision of services based on the identified needs and is designed to provide eligible Medicaid waiver recipients with access to both state plan services as well as certain extended Medicaid covered services.

Nevada acknowledges that people who are suffering from dementia can lead satisfying and productive lives when they are provided with the services and supports to do so.

2401 AUTHORITY

Section 1915(c) of the Social Security Act (SSA) permits states the option to waive certain Medicaid statutory requirements to offer an array of home and community-based services to eligible individuals who may require such services in order to remain in their communities and avoid institutionalization.
Statutes and Regulations:

- SSA: 1915(c) Waiver
- 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)
- 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 441.301(c)(4)(i) through (vi) – HCBS Settings Final Regulation
- 42 CFR 441.301(c)(1) through (5) - Federal Person – Centered Planning and Settings Requirements
- Nevada Assembly Bill (AB) 208 from the 2023 legislative session – SFCG
- NRS 629.091 Personal assistant authorized to perform certain services for person with disability if approved by provider of health care requirements.

2402 RESERVED

2403 POLICY

2403.1 WAIVER ELIGIBILITY CRITERIA

The SFCG Waiver waives certain statutory requirements and is offered to eligible recipients to assist them to remain in their own homes or community.

Eligibility for the SFCG Waiver is determined by the Aging and Disability Services Division (ADSD) and the Division of Welfare and Supportive Services (DWSS).

A. Applicants must have a diagnosis of dementia or related conditions.

1. Applicants must provide SFCG Dementia Verification Form completed and signed by the following acceptable but not limited to medical sources: Licensed physicians (medical or osteopathic doctors), Advanced Practice Nurse (APRN), or Physician Assistant (PA/PA-C) etc.

2. The Data Interchange Standards Association (DISA) screen located in the Nevada Operations of Multi-Automated Data Systems (NOMADS) system cannot be accepted as proof of disability.

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

C. Each applicant/recipient must demonstrate a continued need for the services offered under the SFCG Waiver to prevent placement in an NF or hospital.

D. Each applicant/recipient must require the provision of 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 services are not being provided.

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

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

2403.1A COVERAGE AND LIMITATIONS

1. Services are offered to eligible recipients who, without the waiver services, would require imminent placement in an institutional setting.

2. Recipients on this waiver must meet and maintain Medicaid's eligibility requirements for the waiver for each month in which waiver services are provided.

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

4. Applicant/recipient must be living with the primary caregiver or vice versa.

5. If an applicant is determined 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.

6. 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 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.

7. Waiver services may not be provided while a recipient is 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 Service Plan (PCSP) (or comparable PCSP);

   b. Provided to meet the 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.

8. The SFCG Waiver is limited by legislative mandate to a specific number of recipients who can be served through the waiver per year (slots). When no waiver slots are available,

ADSD utilizes a wait list to prioritize applicants who have been presumed to be eligible for the waiver.

9. This Waiver must be cost neutral. DHCFP total waiver services including other State Plan services' expenditures for all SFCG Waiver recipients will not, in any calendar/waiver year, exceed the cost to provide care in an NF.

2403.1B APPLICANT/RECIPIENT RESPONSIBILITIES

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

Recipients must participate and cooperate with the ongoing case manager including monthly contacts.

Additionally, applicants and/or their designated representative/Legally Responsible Individual (LRI) must:

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

2. Complete and sign all required waiver forms within the specified timeframes.

2403.2 WAIVER SERVICES

DHCFP determines which services will be offered under the HCBS Waiver. Providers and recipients must agree to comply with all waiver requirements for service provision.

2403.2A COVERAGE AND LIMITATIONS

Under this waiver, the following services are covered if identified in the PCSP as necessary to remain in the community and to avoid institutionalization.

1. Case Management

2. Respite Services

3. SFCG Services

2403.2B PROVIDER RESPONSIBILITIES

1. Must obtain and maintain a Medicaid provider number Provider Type (PT) 95 through DHCFP's Fiscal Agent.

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, the providers must also comply with rules and regulations as set forth in the MSM Chapter 100 - Medicaid Program. Failure to comply with any or all of these stipulations may result in DHCFP's decision to exercise its right to terminate the provider's contract.

4. Provider Agency Termination of Waiver Services:

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

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

      2. The recipient or designated representative/LRI requests termination of services;

      3. The recipient or designated representative/LRI is non-cooperative in the establishment or delivery of services, including the refusal to sign required forms;

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

      5. The recipient requires a higher LOC 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 and agencies of the date when services are to be terminated. The case manager should be notified within five business 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 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 and a list of the affected recipients to DHCFP, at least 30 calendar days in advance of service discontinuation; and

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

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

7. Must be responsible for any claims submitted and 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.

8. Must understand that payment for services will be based on the level of service or specific tasks identified in the PCSP.

9. 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 outside of the scope of normal daily activities such as assistance in bathing, dressing, grooming, and toileting.

10. The LRI, family member, or non-relative caregiver must be enrolled with a PCS or Intermediate Service Organization (ISO) agency and living with the recipient or vice versa. Additionally, there can only be one caregiver as the payment will be based on a daily stipend of 65% of the Medicaid service rate.

11. All providers may only provide services that have been identified in the PCSP and have a prior authorization, if required.

12. Must have a backup plan on a short-term basis and there is no other support available during an emergency. For example, the primary caregiver is unable to provide the services due to unforeseen circumstances. 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 PCSP within 60 calendar days from waiver enrollment. If a service has been included in the PCSP and there is no provider assigned, the signature

would not be required until the provider is selected by the individual and would be required within 30 calendar days.

14. Serious Occurrence Report (SOR)

All direct waiver service providers are required to report a SOR within 24 hours of discovery. An electronic 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.

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

a. Suspected physical or verbal abuse;

b. Unplanned hospitalization;

c. Abuse, neglect, exploitation, isolation, abandonment, or unexpected death of the recipient;

d. Injuries requiring medical intervention;

e. Sexual harassment or sexual abuse;

f. Theft;

g. An unsafe working environment;

h. Elopement of a recipient;

i. Medication errors resulting in injury, hospitalization, medical treatment, or death;

j. Death of the recipient;

k. Loss of contact with the recipient for three consecutive scheduled days;

l. Any event which is reported to Adult Protective Services (APS) (18 years old and above), or law enforcement agencies.

m. Criminal Victimization;

n. Financial Exploitation.

The State of Nevada has established mandatory reporting requirements of suspected incidents or abuse, neglect, isolation, abandonment, and exploitation. APS, and/or local 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 waiver providers and its personnel, including owners, officers, administrators, managers, employees, and consultants must undergo State and 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.

Waiver providers that are not subject to DPBH licensure, must provide a state business licensure from their home state.

16. Recipient File

Recipient records must contain PCSP, activities of daily living (ADL) logs, prior authorizations, backup plan, and SORs.

17. Adhere to HIPAA Requirements.

Refer to MSM Chapter 100 – Medicaid Programs for information on HIPAA, privacy and confidentiality of recipient records, and other protected health information (PHI).

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

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

20. Qualifications and Training:

Prior to initial enrollment and revalidation, Provider Agencies must provide certificate of completion of the following trainings specific to dementia and or related conditions:

a. Training in responding to emergencies.

b. Training in working with recipients of SFCG Waiver, including their families.

1. Communication
2. Person-centered service delivery
3. Assessment of persons with dementia
4. Planning the provision of care
5. Assisting with ADL
6. Supporting a caregiver
7. Safety
8. Responding to and managing the beneficiary's behavioral and psychosocial symptoms.

c. Background on dementia.

d. Dementia-related assessments.

e. Decision-making capacity.

f. Abuse, neglect, and exploitation training.

g. Advanced care planning.

All provider agencies must arrange training for employees who have direct contact with recipients and must have service specific training prior to performing a waiver service.

For recipients requiring skilled services such as medication management/administration, wound care, bowel care with suppository, or digital stimulation, etc., "skilled by unskilled" forms must be completed and signed by the health care provider. The skilled by unskilled forms will be provided by the case manager to the recipient or designated representative/LRI to be given to their health care provider. Additionally, to provide the approved skilled services, the primary caregiver must be enrolled under ISO agency.

Note: For more information regarding skilled services that can be performed by unlicensed providers, refer to NRS 629.091.

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

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

23. Information about the specific needs and goals of the recipients to be serviced;

24. Interpersonal and communication skills and appropriate attitudes for working effectively with recipients including: understanding care goals; respecting recipient rights and needs; respect for age, cultural and ethnic differences, be tolerant of varied lifestyles, recognizing family relationships; confidentiality; 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.

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

2403.2C RECIPIENT RESPONSIBILITIES

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

1. Notify the provider(s) and the case manager of any change in Medicaid eligibility.

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

3. Notify the provider(s) and/or case manager of changes in medical status, support systems, service needs, address, or location changes, and/or any change in status of designated representative/LRI.

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

5. Sign and date the provider(s) record(s) at a minimum weekly, to verify services provided. If the recipient is unable to provide a signature due to cognitive and/or physical limitations, this will be clearly documented in the Statement of Choice (SOC) and/or PCSP, as appropriate.

6. Notify the provider or case manager when scheduled visits cannot be kept, missed appointments by the provider agency staff, or services are no longer required.

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

8. Furnish the provider agency with a copy of their Advance Directive if appropriate.

9. Work with the provider agency to establish a back-up plan in case the caregiver 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.

10. Understand that a provider may not work or clean for a recipient's family, household members, or other persons living in the home with the recipient.

11. Not request a provider to perform services not included in the PCSP.

12. Contact the case manager to request a change of provider agency.

13. Complete, sign, date, and submit all required forms within designated timeframe.

14. Comply with the contact schedule outlined in PCSP.

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

16. Initial and sign the weekly log to verify that 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 PCSP.

17. Actively participate in the development of the PCSP which allows the recipient to make informed choices.

2403.3 INTAKE ACTIVITIES

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

2403.3A COVERAGE AND LIMITATIONS

1. Intake Referral Process

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

a. Referral/Application

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

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

2. When an application is received and assigned, the ADSD Intake Specialist will make phone, email, or 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 return the completed SFCG Dementia Diagnosis Verification Form in order to continue the application process.

3. Once the SFCG Dementia Diagnosis Verification form is received, a face-to-face visit is scheduled by the ADSD Intake Specialist within 45 calendar 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 does not meet the waiver requirements, the applicant must be sent a denial Notice of Decision (NOD). NOD issued by the DHCFP Long Term Services and Supports (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 waitlist 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 significant change in support systems and are in a crisis situation;

Level 2: Applicants who have significant change in support system and/or in a crisis situation and require at least maximum assistance in 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, eating/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 will indicate the 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 an NF. If the applicant/designated representative/LRI prefers placement in an 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.

e. During the LOC evaluation, if determined that there was a need for skilled services that may be performed by an unlicensed professional, the intake specialist will provide the skilled by unskilled forms to the recipient or designated representative/LRI to be given to recipient's health care provider to complete and establish the skilled tasks necessary including scope and frequency.

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 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 records.

7. Effective Date for Waiver Services

   The effective date for waiver services may not be any earlier than the date that the inividual is assessed by the case manager or as indicated on the PCSP.

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

8. All applicants will be assigned to a case management agency of their choice. If a case management provider is not selected by the applicant/recipient, upon waiver approval one will be assigned by the ADSD depending on the case management agency availability.

   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, any notes from the Intake Specialist needed to support ongoing services, and a copy of the Medical Assistance to the Aged, Blind and Disabled (MAABD) application submitted to DWSS.

2403.4 CASE MANAGEMENT

Case Management services assist eligible and active Waiver recipients in gaining access to needed waiver and other State Plan services, as well as needed medical, social, education, or other services, regardless of the funding source for the services to which access is gained. Case managers are responsible for ongoing monitoring of the provision of services included in the individual's PCSP.

2403.4A 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. 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. Case management is provided to eligible recipients enrolled in HCBS Waiver programs and must be identified as a service on the PCSP. Case management providers are responsible for confirming the recipient's eligibility each month prior to rendering waiver services. The recipient has a choice of case management providers who are actively enrolled with DHCFP under PT 95.

   There are two components of case management services: administrative activities and direct activities:

   a. Administrative Case Management activities include:

      1. All activities completed by the Intake Specialist prior to Waiver Enrollment.

      2. Facilitating Medicaid eligibility, which may include assistance with the MAABD application and obtaining documents required for eligibility determination.

      3. ADSD Operations Unit review and approval of LOC conducted by the Case Management Provider.

      4. Travel.

      5. Communication and/or data collection provided by the case manager to the quality assurance unit in response to the results of a Participant Survey finding.

6. Request NOD when an adverse action is taken (Denial, suspension, termination, and reduction of services).

7. Any action the case manager takes for a recipient who is in an inactive status. This includes attendance for an Administrative Fair Hearing/Appeal with DHCFP.

8. General Administrative tasks (scheduling visits, voicemail, email communication with DHCFP, scanning and uploading documents, mailing provider lists and/or resources to recipient, telephoning providers for general availability, outreach activities for solicitation, etc.).

b. Direct Case Management activities include:

1. Completion of the Social Health Assessment (SHA) and LOC with the recipient (annual reassessment of eligibility and any change of condition).

Note: If the case manager is unable to complete the SHA during in-person contact with the Waiver recipient, the case manager may bill for the time taken to summarize their findings and create and complete the SHA when they gain access to the document. However, they may not bill for the time taken to repeat the information gathered in person and transfer to the SHA form.

2. PCSP development and follow-up for initiation of waiver services, including any activity related to the prior authorization requests for approval and/or follow-up. During the PCSP development:

a. If it was determined that the recipient has skilled needs including medication management, other skilled services, etc., which can be provided by an unskilled provider, the case manager will provide the recipient or designated representative/LRI a list of ISO providers to choose from.

Note: Recipients requiring skilled services including medication management, or other skilled services, etc., should be determined during the LOC evaluation/re-evaluation. During this time skilled by unskilled forms should have been provided to and completed by the recipient's healthcare provider and returned to the case manager.

b. If no skilled services are needed, the case manager will provide a list of PCS or ISO agencies.

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

4. Any activity related to the prior authorization request, approval, and/or follow-up.

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

6. Resource navigation, facilitation, coordination, and support intended to aid, navigate, and connect with Waiver and Community resources.

   Note: Understanding the case manager may not always be with the recipient while performing resource navigation activities is considered an example and not all inclusive.

7. 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.

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

9. Monitoring and documenting the quality of care through monthly contacts with recipients.

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

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

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

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

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

15. Any adverse actions resulting in suspension, termination, and/or reductions in services.

All services rendered when a recipient is in an active suspended status are considered administrative function and are not billable.

2. Upon assignment of an HCBS SFCG Waiver recipient, the case manager is responsible for conducting a face-to-face SHA and is used for the following:

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

b. Addresses ADLs, Instrumental Activities of Daily Living (IADL), service needs, and support systems.

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

d. Considers 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.

3. The PCSP 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 with information about the recipient's care.

a. The initial and annual written PCSP 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 PCSP 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 PCSP 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 PCSP development, there is no chosen direct waiver provider. The service must still be listed on the PCSP to include the other elements with the providers to be determined (TBD) and must be signed and dated by the recipient 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 PCSP listing the provider must be updated with the date and signatures from the recipient and/or designated representative/LRI and provider during the next face-to-face visit.

The PCSP must include the recipient's chosen method of contact.

d. Changes to the PCSP

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

2. The PCSP does not need to be revised when the 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 record.

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

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

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

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

f. The case manager is responsible for distributing the section of the PCSP which pertains to the specific waiver provider to include the scope, frequency, duration and method of service delivery, recipient's identified goals, risk factors, and mitigation.

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

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

1. Identify a specific and individualized assessed need;

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

3. Document less intrusive methods of meeting the needs 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 monthly. At a minimum, there must be a face-to-face visit with each recipient and/or designated representative/LRI quarterly. All other ongoing contact methods may be determined by the recipient and/or designated representative/LRI.

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 the overall provision of waiver services and determining that the personalized goals identified in the PCSP are being met.

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

PCSP. The case manager also assesses the need for any change in services or providers by reviewing the caregiver's logs.

3. 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.

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 PCSP, the case manager will submit the completed LOC to the Operations Agency for approval.

2. Once received by the 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 Operations Agency, the case manager will complete the prior authorization 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 PCSP 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 their paid caregiver.

c. The annual PCSP 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).

7. Ensure recipients retain freedom of choice in the provision of services. 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.

8. Notifying all affected providers of any unusual occurrences or change in the recipient's medical status, service needs, address, or designated representative/LRI.

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

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

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 PCSP 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.

2403.4B PROVIDER RESPONSIBILITIES

In addition to the provider's responsibilities listed in Section 2403.2B, the provider must:

For Private Case Management Agency

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

2. Meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to the DHCFP MSM Chapters 100 and 2300, as applicable.

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

4. The following requirements must be verified upon enrollment:

   a. Documentation of taxpayer identification

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

   c. Proof of Worker's Compensation Insurance.

   d. Proof of Unemployment Insurance Account.

   e. Proof of Commercial General Liability.

   f. Proof of Business Automobile Liability Coverage.

   g. Proof of Commercial Crime Insurance.

   h. Local or toll-free phone number accessible during traditional business hours (8:00 AM –– 5:00 PM).

   i. Business office that is accessible to the public during established and posted business hours or demonstrate availability to waiver individuals during traditional business hours (8:00 AM – 5:00 PM).

   j. FBI Criminal Background Check.

5. Case Managers must meet the requirements listed below:

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

   b. Adhere to HIPAA requirements.

   c. FBI criminal history background check.

   d. Licensed Social Worker (LSW) by the State of Nevada Board of Examiners for Social Workers, licensed as a Registered Nurse (RN) by the State of Nevada Board of Nursing, or have a professional license or certificate in a medical specialty applicable to the assignment; or have at minimum a Bachelor's degree from an accredited college or university in social work, gerontology, counseling, nursing, psychology, human growth and development, special education, sociology, criminal justice, or a closely related social science or human services field. One year of professional experience providing case management services in a social or health-related field is preferred but can be obtained through on-the-job training; or have an equivalent combination of education and experience.

2403.5 RESPITE CARE

Respite Care Services are provided to recipients unable to care for themselves. This service is provided on a short-term basis due to 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 another private setting.

2403.5A COVERAGE AND LIMITATIONS

1. Respite services may be for 24-hour periods.

2. Respite care is limited to 336 hours for the duration of the PCSP.

3. Services must be prior authorized by the case manager.

2403.5B PROVIDER RESPONSIBILITIES

In addition to the provider's responsibilities listed in Section 2403.2B, Respite Providers must:

1. Provide adequate training related to personal care assistance appropriate for recipients on the SFCG Waiver 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;

2. Service must be prior authorized.

3. As mandated by Nevada statute, federal law, or any other applicable Medicaid authority, providers must adhere to all wage requirements established by federal or state law or applicable Medicaid requirements for direct care workers. Specific wage requirements are referenced in SFCG Waiver in Appendix C – Participant Services and are outlined in the provider enrollment contract. The DHCFP Audit Unit will conduct audits to ensure compliance with any wage requirement. As part of these audits, documents requested may include but are not limited to:

   a. payroll records such as timesheets or timecards;

   b detailed paystubs including hours and rates per direct care worker;

   c. employment documentation used to verify identification and authorization to work;

   d. financial records needed to verify a provider's wage expense.

If a provider is determined to not be in compliance with paying their direct care workers a required wage, a provider will be subject to corrective action. Initial violations for non-compliance may result in provider education as well as recoupment of overpayment due to a provider not paying a direct care worker the mandated wage. Continued violations may trigger corrective action including additional penalties up to termination.

2403.5C RECIPIENTS RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in Section 2403.2C, the recipient must:

1. Agree to utilize an approved Electronic Visit Verification (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 PCSP, the EVV record that reflects the service rendered. If Interactive Voice Response (IVR) is utilized, a vocal confirmation is required.

2403.6 SFCG SERVICES

SFCG preserves the dignity, self-respect, and privacy of the recipient by ensuring high quality care in a non-institutional setting. The goal of this service is to provide necessary care while fostering and emphasizing the recipient's independence in a home environment that will provide the recipient with a range of care options as their needs change. This waiver provides the recipient with the option to receive personal care and related supports.

2403.6A COVERAGE AND LIMITATIONS

1. Primary caregiver must be living in the same private residence as the recipient.

2. SFCG may be provided on an episodic or on a continuing basis.

3. The primary caregiver may be a non-family member, a family member, or an LRI performance of.

4. The supports provided within the home are managed and completed throughout the day based on the participant's daily needs.

5. Attendant care services related to needed ADLs, including skilled nursing care and medication administration, to the extent permitted by state law. NRS 629.

6. Homemaker service is the general household tasks (e.g. light housekeeping, meal preparation, essential shopping, laundry, and routine household care).

7. As part of these services, accompany the recipient to community activities that are therapeutic in nature if appropriate or assist with maintaining natural supports.

8. SFCG is only provided to individuals age 21 and over. All medically necessary SFCG services for children under age 21 are covered in the State Plan pursuant to the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.

9. This service must be prior authorized.

2403.6B PROVIDER RESPONSIBILITIES

In addition to the provider's responsibilities listed in Section 2403.2B, Respite Providers must:

1. Services must be prior authorized.

2. Provider agency to ensure direct care workers are provided the required training (certificate of completion must be in the employee file) prior to rendering SFCG services. See Section 2403.2B(20) for the list of required training.

3. If it is determined that a recipient has skilled needs that can be performed by an unlicensed direct care worker, the provider agency must obtain approval from and be trained by a licensed professional healthcare provider. See Section 2403.2B.20(7) for instruction on skilled services.

4. As mandated by Nevada statute, federal law, or any other applicable Medicaid authority, providers must provide a daily stipend established by federal or state law or applicable Medicaid requirements for direct care workers. Specific daily stipend is referenced in SFCG Waiver in Appendix C – Participant Services and is outlined in the provider enrollment contract. DHCFP will conduct audits to ensure compliance with daily stipend requirement. As part of these audits, the documents requested may include detailed paystubs to validate that the direct care worker receives 65% of the Medicaid daily rate for SFCG service.

   Note: If a provider is determined to not be in compliance with paying their direct care workers the required daily stipend, initial violations for non-compliance may result in provider education as well as recoupment of overpayment. Continued violations may trigger corrective action including additional penalties up to termination.

2403.6C RECIPIENT RESPONSIBILITIES

See Recipient Responsibilities outlined in Section 2403.2C.

2403.7 DHCFP LTSS INITIAL REVIEW

Once the applicant has been approved for the waiver, DHCFP LTSS 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 NF LOC criteria;

2. At least one waiver service identified:

3. The SOC is completed with signature and dates; and

4. The HCBS Acknowledgement Form complete including initials, signature, and date.

5. The skilled by unskilled forms, if applicable.

   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.

2403.8 WAIVER COSTS

DHCFP must assure CMS that the average per capita expenditure 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.

2403.9 QUALITY ASSURANCE WAIVER REVIEW

The state conducts an annual review of active waiver participants. 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 SFCG Waiver to evaluate operation.

Case management and direct waiver service providers must cooperate with ADSD Operations and DHCFP's review process.

2403.10 PROVIDER ENROLLMENT

All providers must maintain a Medicaid services provider agreement and comply with the criteria set forth in Nevada MSM Chapter 100 and MSM Chapter 2200. Provider Enrollment checklists and forms can be found on the Fiscal Agent's website https://www.medicaid.nv.gov.

2403.11 BILLING PROCEDURES

DHCFP assures that claims for payment of waiver services are made only when a recipient is Medicaid eligible, when the service(s) are identified on the approved PCSP, and the service(s) have been prior authorized.

Refer to the Fiscal Agent's website at: www.medicaid.nv.gov for the Provider Billing Guide Manual.

2403.12 ADVANCE DIRECTIVES

Section 1902(w) of the SSA requires licensed providers to provide their recipients with information regarding 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 at the local ADSD office. Whether a recipient chooses to write their own Advance Directives or complete an Advance Directives form in full is the individual choice of each applicant and/or designated representative/LRI.

2404 HEARINGS REQUESTS DUE TO ADVERSE ACTIONS

An adverse action refers to denials, terminations, reductions, or suspensions of the applicant/recipient's request for services or an applicant/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 the case manager.

2404.1 SUSPENDED WAIVER SERVICES

When a recipient is institutionalized for less than 60 days, their waiver services must be suspended.

A. Upon receipt of the suspension notification, DHCFP LTSS will issue a suspension NOD to the recipient.

B. Waiver services will not be paid for the days that a recipient's eligibility is in suspension.

C. 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.

2404.2 RELEASE FROM SUSPENDED WAIVER SERVICES

When a recipient has been released from an institution, before the 60th day from the admit date, the case manager must do the following within five business days of the recipient's discharge:

A. Complete a reassessment if there has been a significant change in the recipient's condition or status;

B. Complete a new PCSP if there has been a change in waiver services. If a change in services is expected to be resolved in less than 30 days, a new PCSP is not necessary. Documentation of the temporary change must be noted in the case manager's narrative. The date of resolution must also be documented in the case manager's narrative; and

C. Contact the service provider(s) to reestablish services.

2404.3 DENIAL OF WAIVER ELIGIBIITY

Basis of denial for waiver services:

A. The applicant does not meet the LOC criteria for NF placement.

B. The applicant has withdrawn their request for waiver services.

C. The applicant fails to cooperate with the case manager in establishing program eligibility or waiver services. (The applicant's and/or designated representative/LRI's signature is necessary for all required paperwork.)

D. The applicant's support system is not adequate to provide a safe environment during the time when waiver services are not provided.

E. The case manager has lost contact with the applicant.

F. The applicant/recipient fails to show a need for waiver services.

G. The applicant would not require NF placement within 30 days or less if waiver services were not available.

H. The applicant has moved out of state.

I. Another agency or program will provide the services.

J. ADSD has filled the number of positions (slots) allocated. The applicant has been placed on the priority waitlist in the order of application date and will be contacted when a slot is available.

K. There are no enrolled Medicaid providers or facilities in the applicant's area.

L. The applicant is in an institution (e.g. hospital, NF, correctional facility, Intermediate Care Facility (ICF) and discharge within 60 calendar days is not anticipated.

M. 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 the application and/or request for waiver services 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 the denial.

2404.4 REDUCTION OR DENIAL OF DIRECT WAIVER SERVICES

Basis of reduction or denial of direct waiver services:

A. The recipient no longer requires the waiver service, number of service hours, or level of service which was previously authorized.

B. The recipient has requested a reduction of services, or a specific waiver service to be discontinued.

C. Another service will be substituted for the existing service, or there is a reduction or termination of a specific waiver service.

D. 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 in waiver services, the case manager will identify the reason for the reduction and what the service will be reduced to and request 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.

2404.5 TERMINATION OF WAIVER PROGRAM ELIGIBILITY

Reasons to terminate from the waiver program:

A. The recipient no longer meets the LOC criteria for NF placement.

B. The recipient and/or designated representative/LRI have requested termination of the waiver program.

C. The recipient and/or designated representative/LRI has failed to cooperate with the case manager or HCBS waiver service provider(s).

D. The recipient fails to show a continued need for HCBS waiver services.

E. The recipient no longer requires NF placement within 30 calendar days if HCBS were not available.

F. The recipient has moved out of state.

G. The recipient and/or designated representative/LRI have participated in activities designed to defraud the waiver program.

H. Another agency or program will provide the services.

I. The recipient has been, or is expected to be, institutionalized over 60 days (in a hospital, NF, correctional facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)).

J. The case manager has lost contact with the recipient.

K. The recipient's support system is not adequate to provide a safe environment during the time when HCBS waiver services are not being provided.

L. HCBS waiver services are not adequate to ensure the health, welfare, and safety of the recipient.

M. The recipient has failed to cooperate with the case manager or HCBS waiver service provider(s) in establishing and/or implementing the PCSP, implementing waiver services or verifying eligibility for waiver services (the recipient and/or designated representative/ LRI's signature is necessary on all required paperwork.).

N. The recipient's swallowing ability is not intact and requires skilled service for safe feeding/nutrition.

O. The recipient has been placed in a residential facility for groups.

P. Death of recipient.

When a recipient is terminated from the waiver program, the case manager will request that the DHCFP LTSS Unit send a NOD. DHCFP LTSS will issue a termination 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 notice and recipient hearings.

2404.6 REAUTHORIZATION WITHIN 90 DAYS OF WAIVER TERMINATION

If a recipient is placed in an NF, hospital, or is incarcerated and waiver eligibility has been terminated, the recipient may request to be re-instated within 90 days from the date of action on the NOD.

2404.6A 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:

   a. They still meet LOC; and

b. They are released/discharged within 90 days.

3. If 91 calendar days have elapsed from the date of action on the NOD, the slot is allocated to the next person on the waitlist.

2404.6B 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 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 2403.4A(3)(d) for requirements.

2404.6C 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.

2405 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 they are given the Recipients Rights form.