MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

January 26, 2021

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: JESSICA KEMMERER, HIPAA PRIVACY AND CIVIL RIGHTS OFFICER

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 2100 – HOME AND COMMUNITY BASED SERVICES WAIVER FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 2100 – Home and Community Based Services Waiver for Individuals with Intellectual and Developmental Disabilities are being proposed to bring this chapter in line with the current waiver renewal which was approved on October 1, 2018.

Updates to this chapter include changing the term "Home and Community Based Waiver" to "Home and Community Based Services" throughout the chapter to adhere to CMS guidance; changing the acronym "HCBW" to "HCBS" throughout the entire chapter; all references to "Waiver for Individuals with Intellectual Disabilities and Related Conditions" have been removed and replaced with "Waiver for Individuals with Intellectual and Developmental Disabilities (ID Waiver)" as defined by Nevada Revised Statutes (NRS) 435.007; changing the form referred to as "NMO-2734" as a "notification" throughout the entire chapter; replacing Individual Support Plan (ISP) to Person Centered Plan (PCP) to adhere to the HCBS New Settings Rule; changing "case manager" to "service coordinator" throughout the entire chapter; expanding the term "authorized representative" to "designated representative/LRI" throughout the entire chapter; changing "individuals" to "recipients" throughout the entire chapter; adding citation MSM 2103.2A to all provider responsibilities/qualifications sections to avoid duplicative language throughout the entire chapter; added new section - Recipient Rights and Responsibilities to each waiver services for consistency throughout the chapter.

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 February 1, 2021.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 02/21 CHAPTER 2100 – HOME AND COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES	MTL 20/15 CHAPTER 2100 – HOME AND COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2100	**Introduction**	Terminology and acronyms updated per the description provided in the Background and Explanation section above. The section was reworded and updated for consistency throughout the chapter and clarity. Replaced 2nd paragraph with The Home and Community Based Services (HCBS) Program for Individuals with Intellectual and Developmental Disabilities (ID Waiver) is an optional service approved by the Centers for Medicare and Medicaid Services (CMS), which authorizes the DHCFP 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 access to both state plan as well as certain extended Medicaid covered services. Some language from Authority Section was moved to Introduction.
2101	**Authority**	Terminology and acronyms updated per the description provided in the Background and Explanation section above. The second paragraph was deleted as portions of the wording was used in the Introduction. The citations for CFR, NRS and NAC was updated for consistency with all Medicaid Service Manuals.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Added citations NAC Chapter 632, HIPAA, MSM 100 and Section 3715 of the CARES Act.
2103.1	**Waiver Eligibility Criteria**	Terminology and acronyms updated per the description provided in the Background and Explanation section above. "Nevada" was replaced with "The HCBS ID". Moved eligibility criteria requirements from its original manual section. Removed "office staff and authorized by the DHCFP's Central Office Staff." Replaced "psychologist" with "Intake Team" and added "assessments and/or". Added "This support system must be in place to ensure the physical, environmental, and basic care needs of the applicant/recipient are met in order to" and clarified eligibility language. Clarified who determines the financial eligibility and combined two paragraphs for consistency.
2103.1A	**Coverage and Limitations**	Terminology and acronyms updated per the description provided in the Background and Explanation section above. Changed "waiver year" to "biennium." Language was updated for policy clarity. Added Section 3715 of the CARES Act policy to item 4. Added "1915(c) waiver" to item number 5. Added "spouse," removed "health/medical care," and replaced and/or updated "child" with "recipient" Added "there is no LRI residing in the recipient's home" and "or the recipient's support team has

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		documented a need for ADL or IADL habilitative services to be provided by direct support staff." Removed "Without this verification, HCBW services will not be authorized." Early and Periodic Screening, Diagnostic and Treatment (EPSDT) was moved to the Coverage and Limitations from the previous location.
2103.1B	**Provider Responsibilities**	Added new section "Providers are responsible for confirming the recipient's Medicaid eligibility each month prior to rendering waiver services."
2103.1C	**Recipient Rights and Responsibilities**	Added new section "Applicants or recipients must meet and maintain all criteria to be eligible, and to remain on the ID Waiver."
2103.2	**Waiver Services**	Terminology and acronyms updated per the description provided in the Background and Explanation section above. Removed "and the state budget process," "Providers and recipients must agree to comply with the requirements for service provision in accordance with ADSD and the DHCFP policies." and "for individuals who have been assessed to be at risk for ICF/IID placement without the provision of enhanced supports as identified in the Individual Support Plan (ISP)." The list of services provided was updated according to the Waiver Application.
2103.2A	**Provider Responsibilities**	Terminology and acronyms updated per the description provided in the Background and Explanation section above. Changed "All Providers" to "Provider Requirements." Updated approval and certification to include NAC 435 and ADSD Policy and Procedures added in Item a.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Added requirement to obtain and maintain a Service Provider Agreement with ADSD prior to providing services to waiver recipients added in Item b. Enrollment language was updated to add "Fee-for-Service Nevada Medicaid" and to reference to MSM Chapters 100 and 2100 added in Item c. Added the requirement to follow the PCP and Service Authorization for prior authorization of waiver services. Added requirement for providers to provide copy of all renewal of professional licenses/certifications. Added cooperation with the ADSD and/or State or Federal reviews and/or inspections. Removed language regarding provider enrollment that duplicates language in MSM Chapter 100 and the fiscal agent provider enrollment checklist. Added "subcontractors and volunteers who have contact with recipients or access to their financial or personal information" to those requiring background checks. Added requirement to maintain background check information on file for 5 years and references to the appropriate NRS and NAC. Added required training for providers that outlines the documentation must be kept on file and available for review, new employee orientation must be completed within 6 months, annual training requirements, providers must comply with established by ADSD.
2103.2B	**Recipient Rights Responsibilities**	Terminology and acronyms updated per the description provided in the Background and Explanation section above. Added "Rights" to "Recipient Responsibilities" throughout the chapter.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Added first paragraph, "The Recipients are entitled to their privacy; to be treated with respect; and be free from coercion and restraint." Added Item 8, "Notify the ADSD and the provider if services are no longer requested or required." Added Item 16, "Cooperate with all the ADSD meetings and contacts such as phone/face-to-face as per the PCP."
2103.3	**Day Habilitation**	Terminology and acronyms updated per the description provided in the Background and Explanation section above. Service Coordination has been moved to another section of this chapter and re-arranged the section Added language to include volunteer work in the community, retirement activities and alternate schedules to allow for participation with activities in the community.
2103.3A	**Coverage and Limitation**	Terminology and acronyms updated per the description provided in the Background and Explanation section above.
2103.3B	**Provider Responsibilities**	Removed all duplicated language and added a reference to MSM 2103.2A for details.
2103.3C	**Recipient Rights and Responsibilities**	Added this section and reference MSM 2103.2B for details to be consistent with other sections in this chapter.
2103.4	**Residential Support Services**	Terminology and acronyms updated per the description provided in the Background and Explanation section above. Clarified policy regarding the habilitation plans and the information addressed. Updated the list of included supports for clarification. Added language to allow the recipient freedom in their residence.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Shared Living Arrangement was defined. Removed reference to provider owned homes in rural areas. Language was updated for clarity regarding the duplication and authorization of services.
2103.4A	**Coverage and Limitations**	Terminology and acronyms updated per the description provided in the Background and Explanation section above. Added verification of certifications must be maintained in employee files. Updated language and policy regarding the residential supports and the delivery of said services. Replaced "Host Home" with "Shared Living Arrangement."
2103.4B	**Provider Responsibilities**	Removed all duplicated language and added a reference to MSM 2103.2A for details. Added requirements specific to residential supports that are not contained in the noted MSM.
2103.4C	**Recipient Rights and Responsibilities**	Added this section and reference MSM 2103.2B for details to be consistent with other sections in this chapter.
2103.5	**Prevocational Services**	Terminology and acronyms updated per the description provided in the Background and Explanation section above. The service description was updated to align with the CMS approved waiver application and for clarity.
2103.5A	**Coverage and Limitations**	Terminology and acronyms updated per the description provided in the Background and Explanation section above.
2103.5B	**Provider Responsibilities**	Removed all duplicated language and added a reference to MSM 2103.2A for details.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2103.5C	**Recipient Rights and Responsibilities**	Added this section and reference MSM 2103.2B for details to be consistent with other sections in this chapter.
2103.6	**Supported Employment**	Terminology and acronyms updated per the description provided in the Background and Explanation section above. Updated language and clarified the language and policy regarding the two sub-categories, Individual Supported Employment and Small Group Supported Employment. Individual Supported Employment was updated to add the description of what will not qualify for payment. Small Group Employment was updated to add similar language from the CMS approved waiver application. Deleted language that was duplicative within this section.
2103.6A	**Coverage and Limitations**	Terminology and acronyms updated per the description provided in the Background and Explanation section above. Updated citation language to reflect the appropriate sources of the policy language and coverages. Deleted verbiage in Item 3 as it is duplicative of MSM 2103.6. Added "Supported Employment services do not include facility-based work settings, or other similar types of vocational services furnished in specialized facilities that are not a part of the general workforce." Added "Recipients who receive Supported Employment services may receive two or more types of non-residential support services; however, different types of non-residential support services may not be billed during the same period of the day."
2103.6B	**Provider Responsibilities**	Removed all duplicated language and added a reference to MSM 2103.2A for details.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2103.6C	**Recipient Rights and Responsibilities**	Added this section and reference MSM 2103.2B for details to be consistent with other sections in this chapter.
2103.7	**Behavioral Consultation, Training and Intervention**	Terminology and acronyms updated per the description provided in the Background and Explanation section above.
2103.7A	**Coverage and Limitations**	Terminology and acronyms updated per the description provided in the Background and Explanation section above. Participation in PCP, Team meetings and medical appointments, monthly summary of progress added to the included services. Added requirement that written authorization is needed for amounts in excess of the limit.
2103.7B	**Provider Responsibilities and Qualifications**	Terminology and acronyms updated per the description provided in the Background and Explanation section above. Removed all duplicated language and added a reference to MSM 2103.2A for details. Clarified the Professional level of licensure details.
2103.7C	**Recipient Rights and Responsibilities**	Added this section and reference MSM 2103.2B for details to be consistent with other sections in this chapter.
2103.8	**Counseling Services**	Terminology and acronyms updated per the description provided in the Background and Explanation section above. Participation in PCP, Team meetings and medical appointments, monthly summary of progress added to the included services.
2103.8A	**Coverage and Limitations**	Removed services included for simplicity and added requirement that written authorization is needed for amounts in excess of the limit.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2103.8B	**Provider Responsibilities and Qualifications**	Terminology and acronyms updated per the description provided in the Background and Explanation section above. Removed all duplicated language and added a reference to MSM 2103.2A for details. Clarified supervision requirements.
2103.8C	**Recipient Rights and Responsibilities**	Added this section and reference MSM 2103.2B for details to be consistent with other sections in this chapter.
2103.9	**Residential Support Management**	Terminology and acronyms updated per the description provided in the Background and Explanation section above. Removed details regarding Targeted Case Management, support managers assisting with management of residential supports.
2103.9A	**Coverage and Limitations**	Terminology and acronyms updated per the description provided in the Background and Explanation section above. Added details regarding Targeted Case Management, support managers assisting with management of residential supports.
2103.9B	**Provider Responsibilities and Qualifications**	Terminology and acronyms updated per the description provided in the Background and Explanation section above. Removed all duplicated language and added a reference to MSM 2103.2A for details. Added one year of experience meeting QIDP qualification.
2103.9C	**Recipient Rights and Responsibilities**	Added this section and reference MSM 2103.2B for details to be consistent with other sections in this chapter.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2103.10	**Non-Medical Transportation**	Non-Medical Transportation Terminology and acronyms updated per the description provided in the Background and Explanation section above. Added "recreational" and "activities are not all inclusive."
2103.10A	**Coverage and Limitations**	Terminology and acronyms updated per the description provided in the Background and Explanation section above. Added a $100 fee limit per month per recipient.
2103.10B	**Provider Responsibilities**	Terminology and acronyms updated per the description provided in the Background and Explanation section above. Removed all duplicated language and added a reference to MSM 2103.2A for details. Clarified policy regarding the verification of safe driving record and completion and ongoing verification of safety inspections.
2103.10C	**Recipient Rights and Responsibilities**	Added this section and reference MSM 2103.2B for details to be consistent with other sections in this chapter.
2103.11	**Nursing Services**	Terminology and acronyms updated per the description provided in the Background and Explanation section above. Language was updated to the 3 components of services to "Medial Management", "Nursing Assessment", and "Direct Services". Sections of the policy was moved, and some portions deleted within this section to align with the nursing services. Direct Service description and policy was added.
2103.11A	**Coverage and Limitations**	Terminology and acronyms updated per the description provided in the Background and Explanation section above.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Duplicated language was deleted. Added the requirement to include notes and summary of Nursing services on all nursing activities.
2103.11B	**Provider Responsibilities and Qualifications**	Terminology and acronyms updated per the description provided in the Background and Explanation section above. Removed all duplicated language and added a reference to MSM 2103.2A for details.
2103.11C	**Recipient Rights and Responsibilities**	Added this section and reference MSM 2103.2B for details to be consistent with other sections in this chapter.
2103.12	**Nutritional Counseling Services**	Terminology and acronyms updated per the description provided in the Background and Explanation section above. Added description of services that may be included under Nutritional Counseling.
2103.12A	**Coverage and Limitations**	Terminology and acronyms updated per the description provided in the Background and Explanation section above. Removed all duplicated language.
2103.12B	**Provider Responsibilities and Qualifications**	Terminology and acronyms updated per the description provided in the Background and Explanation section above.
2103.12C	**Recipient Rights and Responsibilities**	Added this section and reference MSM 2103.2B for details to be consistent with other sections in this chapter
2103.13	**Career Planning**	Terminology and acronyms updated per the description provided in the Background and Explanation section above. Service description updated to include time limited and focus on career direction and development, activities to assist in the identification of employment

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		goals, providers to collaborate with the development of career goals and set forth guidelines for the services.
2103.13A	**Coverage and Limitations**	Terminology and acronyms updated per the description provided in the Background and Explanation section above. Updated time limit from 40 days to 216 hours within a 6-month time period per year. Added limitation of services under programs funded by section 110 of the Rehabilitation Act of 1973.
2103.13B	**Provider Responsibilities**	Terminology and acronyms updated per the description provided in the Background and Explanation section above. Added policy regarding the verification of safe driving record and completion and ongoing verification of safety inspections. Deleted duplicated language.
2103.13C	**Recipient Rights and Responsibilities**	Added this section and reference MSM 2103.2B for details to be consistent with other sections in this chapter.
2103.14	**Intake Procedures**	Terminology and acronyms updated per the description provided in the Background and Explanation section above. Removed "Coverage and Limitations" section for consistency with other sections of this chapter. Removed Waiver Slot Provision and under this heading, language was moved to another area of this section and some were deleted due to duplicated language. Re-arranged this section for clarity and consistency. Language was added and reworded throughout this section for clarity and consistency.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Deleted language on Item 2d.5 as it is not applicable. Deleted language Item 4 under Effective Date for Waiver Services for simplicity and clarity. Support Plan Development was added to provide more specifics on how to develop appropriate support plan in accordance with the PCP.
2103.15	**Permanent Case File**	Terminology and acronyms updated per the description provided in the Background and Explanation section above. Reworded language for clarity and consistency.
2103.16	**Service Coordinator Recipient Contacts**	Terminology and acronyms updated per the description provided in the Background and Explanation section above. Reworded language for clarity and consistency. Added language on Items A2a and 2b. Added language on Item B3 and removed and reworded language.
2103.17	**Billing Procedures**	Terminology and acronyms updated per the description provided in the Background and Explanation section above. Deleted Coverage and Limitations for consistency with other sections in this chapter.
2103.18	**DHCFP Annual Review**	Terminology and acronyms updated per the description provided in the Background and Explanation section above. Removed Coverage and Limitations to be consistent with other sections in this chapter. Under this section added Assurances and Sub-Assurances to align with the currently approved ID Waiver application.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2104	**Hearings**	Added "REQUEST DUE TO ADVERSE ACTIONS" and introduction to Hearings, "An adverse action refers to denials, terminations, reductions or suspensions of a recipient's eligibility determination or an applicant's request for services. The DHCFP must grant an opportunity for a hearing to an applicant/recipient/designated representative/LRI in the event an adverse action is taken by the DHCFP."
2104.1	**Suspended Waiver Services**	This section has been added as recipients are entitled to a fair hearing during suspension status.
2104.2	**Release from Suspended Waiver Services**	The entire section has been added.
2104.3	**Denial of Waiver Application**	Terminology and acronyms updated per the description provided in the Background and Explanation section above. Removed Item l, as it is not applicable.
2104.4	**Termination of Waiver Services**	Terminology and acronyms updated per the description provided in the Background and Explanation section above. Added "Death of recipient." Added at the end of this section, "When a recipient has a reduction of waiver services, the Service Coordinator will send a notification to the DHCFP LTSS Unit identifying the reason for the reduction and what the service is being reduced to. The LTSS Unit will send a NOD to the recipient or the recipient's designated representative/LRI. The form must be mailed by the DHCFP to the recipient at least 13 calendar days before the DOA on the NOD" and "When a recipient is denied waiver services, the Service Coordinator will send a notification to the DHCFP LTSS Unit identifying the reason for the denial. The LTSS Unit will send a NOD to the recipient or the recipient's designated representative/LRI within five days, identifying the reason for denial. The DOA is the same day of the NOD."

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2104.5	**Reduction or Denial of Waiver Services**	Terminology and acronyms updated per the description provided in the Background and Explanation section above.
2104.6	**Reauthorization within 90 Days**	Coverage and Limitations has been deleted for consistency with other sections of this chapter. Added from a previous section, "When a recipient is placed in an institutional setting such as nursing facility, ICF/IID, or hospital, they must be sent a NOD terminating them from the waiver 60 days from admit date. Their waiver slot must be held for 90 days from the NOD date. A recipient may be placed back in that slot if they are released within 90 days of the NOD date, and request reinstatement, but must continue to meet waiver eligibility criteria. After 90 days, their slot may be given to the next individual on the wait list." Provider Responsibilities has been omitted for consistency with other sections of this chapter.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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HOME AND COMMUNITY BASED WAIVER

2100 INTRODUCTION

The Division of Health Care Financing and Policy (DHCFP) and the Aging and Disability Services Division (ADSD) recognizes that many individuals at risk of being placed in Intermediate Care Facilities (ICFs) can be cared for in their homes and communities, preserving their independence and ties to family and friends at a cost no higher than that of institutional care.

The Home and Community Based Services (HCBS) Program for Individuals with Intellectual and Developmental Disabilities (ID Waiver) is an optional service approved by the Centers for Medicare and Medicaid Services (CMS), which authorizes the DHCFP 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 access to both state plan as well as certain extended Medicaid covered services.

Nevada acknowledges that people who have intellectual and developmental disabilities are able to lead satisfying and productive lives when they are provided the needed services and supports to do so. The DHCFP is committed to the goal of providing individuals with intellectual and developmental disabilities with the opportunity to remain in a community setting in lieu of institutionalization.

2101 AUTHORITY

Section 1915(c) of the Social Security Act permits states the option to waive certain Medicaid statutory requirements in order to offer an array of HCBS to eligible individuals who may require such services in order to remain in their communities and avoid institutionalization. The DHCFP's HCBS for Individuals with Intellectual and Developmental Disabilities is approved by the CMS. This waiver is designed to provide eligible Medicaid waiver recipients access to both 1905(a) State Plan services as well as certain extended Medicaid covered services unique to this waiver. The goal is to allow recipients to live in their own homes or community settings.

Statutes and Regulations:

- Social Security Act: 1915 (c)
- Title 42 Code of Federal Regulations (CFR) Section 441, Subpart I (Community Supported Living Arrangements Services)
- Title 42 CFR Section 483.430(a) (Qualified Intellectual Disabilities Professional (QIDP))
- Nevada Revised Statute (NRS) Chapter 435 (Individuals with Intellectual Disabilities and Developmental Disabilities)
- Nevada Administrative Code (NAC) Chapter 435 (Individuals with Intellectual Disabilities and Developmental Disabilities)
- NAC Chapter 632 (Nursing)
- Health Insurance Portability and Accountability Act (HIPAA)
- Medicaid Service Manual (MSM) Chapter 100
- Section 3715 of the CARES Act

2102 RESERVED

2103 POLICY

2103.1 WAIVER ELIGIBILITY CRITERIA

The HCBS ID Waiver waives certain statutory requirements and offers waiver services to eligible recipients to assist them to remain in the community. The target population for this waiver includes all individuals who are diagnosed with intellectual disabilities or developmental disabilities and who have been found eligible and have an open case with an ADSD Regional Center. Individuals are eligible if they meet Medicaid's eligibility requirements and are either in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or are at risk for ICF/IID placement without the provision of HCBS and supports.

Eligibility for the ID Waiver is determined by the combined efforts of ADSD, the DHCFP and the Division of Welfare and Social Services (DWSS). Two separate determinations must be made to be eligible for and receive services under the ID Waiver:

a. Service eligibility for the ID Waiver is determined by an ADSD's Regional Center.

   1. An ADSD Regional Center Intake Team, based on assessments and/or supporting documentation, establishes the existence of an intellectual disability or developmental disability.

   2. Each applicant/recipient must meet and maintain Level of Care (LOC) for admission into an ICF/IID. Specifically, the individual would require imminent placement in an ICF/IID facility (within 30 to 60 days) if HCBS Waiver services or other supports were not available.

   3. Each applicant/recipient must demonstrate a continued need for a waiver service(s) to prevent placement in an ICF/IID. Sole utilization of Medicaid State Plan Services does not support the qualifications to be covered by the waiver.

   4. The applicant/recipient must have a support system in place to ensure the physical, environmental, and basic care needs of the applicant/recipient are met in order to provide a safe environment during the hours when services are not being provided. HCBS Waiver services are not a substitute for available natural and informal supports provided by family, friends or other available community resources.

b. The financial eligibility determination for Medicaid benefits is made by the DWSS. Waiver applicants/recipients must meet and maintain Medicaid eligibility coverage for all months in which waiver services are provided.

c. Services from the ID Waiver cannot be provided until and unless the applicant is found eligible in both determination areas.

2103.1A COVERAGE AND LIMITATIONS

1. Waiver recipients must meet and maintain Medicaid's eligibility coverage through the DWSS for all months waiver services are being provided.

2. The ID Waiver is limited by legislative mandate and available matching state funding to a specific number of recipients who can be served throughout the biennium. A waitlist is utilized to prioritize applicants who have been presumed to be eligible for the waiver as defined below.

   a. First priority is individuals residing in an ICF/IID or other institutional settings.

   b. Second priority is individuals who are at risk of institutionalization due to loss of their current support system or crisis situation.

   c. Third priority is all individuals, deemed appropriate for waiver services, who do not fall under priority one or two, based on the date of request for a waiver service.

3. The DHCFP must assure the CMS that Medicaid's total expenditures for waiver and Medicaid State Plan services will not, in any waiver year, exceed 100% of the amount that would be incurred by Medicaid for these individuals in an institutional setting in the absence of the waiver. The DHCFP must also document that there are safeguards in place to protect the health and welfare of recipients.

4. Waiver services must not be billed when an individual is admitted to an institutional setting, such as a hospital, ICF/IID or nursing facility (NF) for the duration of the stay. Residential settings that bill per diem may bill the per diem rate for admit and discharge days only when services were provided and documented for some part of the days in question. Residential settings that bill by the unit or hour may bill for services provided and documented on admit and discharge days.

   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 support plan (or comparable 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.

5. If an applicant/recipient is determined eligible for more than one HCBS Waiver, the individual cannot receive services under two or more such 1915(c) waivers at the same time. The applicant/recipient must choose one HCBS Waiver and receive services provided by that waiver.

6. Recipients of the ID 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. Collaborative case coordination between the hospice agency and the waiver Service Coordinator is required to prevent any duplication of services. Refer to MSM Chapter 3200 for additional information on hospice services.

7. An able and/or capable parent, spouse or Legally Responsible Individual (LRI) of a recipient has a duty/obligation to provide the necessary maintenance, education, supervision and support. Necessary maintenance includes but is not limited to, the provision of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). Payment will not be made for the routine care, supervision or services normally provided for the recipient without charge as a matter of course in the usual relationship among members of the nuclear family. Waiver services are not a substitute for available natural and informal supports provided by family, friends or other available community resources; however, they are available to supplement those support systems, so the recipient is able to remain in their home.

   Allowance may be given in individual circumstances when:

   a. there is no LRI residing in the recipient's home;

   b. or there is no other LRI residing in the home and an able and/or capable spouse/parent's employment requirements result in prolonged or unexpected absences from the home;

   c. or when such employment requirements require the able and/or capable spouse/parent or LRI to work uninterrupted at home in order to meet the requirement of his or her employer;

d. or when employment requirements include unconventional work weeks or work hours;

e. or the recipient's support team has documented a need for ADL or IADL habilitative services to be provided by direct support staff.

The LRI may be asked to provide verification from a physician, place of employment, or school that they are not capable, due to illness or injury, or unavailable, due to hours of employment and school attendance, to provide services. Additional verification may be required on a case by case basis.

8. LRIs may not be reimbursed for HCBS Waiver services.

9. Legal guardians of individuals age 18 and over are considered LRIs.

10. The children made eligible for Medicaid through their enrollment in the Waiver for Individuals with Intellectual and Developmental Disabilities receive all the medically necessary Medicaid coverable services available under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). A child's enrollment in the waiver will not be used to deny, delay, or limit access to medically necessary services that are required to be available to Medicaid-eligible children under federal EPSDT rules. The waiver service package is a supplement to EPSDT services.

2103.1B PROVIDER RESPONSIBLITIES

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

2103.1C RECIPIENT RESPONSIBLITIES

Applicants or recipients must meet and maintain all criteria to be eligible, and to remain on the ID Waiver.

2103.2 WAIVER SERVICES

The ADSD, the operating agency for the ID waiver, in conjunction with the DHCFP, the administrating agency determines which services will be offered under the ID Waiver.

Under this waiver, the following services are available:

A. Day Habilitation.

B. Residential Support Services.

C. Prevocational Services.

D. Supported Employment.

E. Behavioral Consultation, Training and Intervention

F. Counseling Services.

G. Residential Support Management.

H. Non-Medical Transportation.

I. Nursing Services.

J. Nutrition Counseling Services.

K. Career Planning.

2103.2A PROVIDER RESPONSIBILITIES

1. Provider Requirements:

a. Must obtain approval or certification, as applicable, from ADSD/Developmental Services (DS) pursuant to Nevada Revised Statute (NRS) 435, Nevada Administrative Code (NAC) 435 and the ADSD Policy and Procedures.

b. Must obtain a Master Service Agreement through Department of Administration Purchasing Division and a Provider Service Agreement through the ADSD.

c. Must enroll as a Provider Type 38 with Fee-for-Service Nevada Medicaid, meet and maintain all the requirements to be enrolled as a Medicaid provider pursuant to MSM Chapter 100 and 2100.

d. May not bill for services provided by an LRI.

e. May only provide and bill for services that have been authorized in the PCP. Prior authorization for waiver services is made through the recipient's PCP and Service Authorization.

f. Must verify the Medicaid eligibility status of each HCBS Waiver recipient each month.

g. Upon renewal of professional licenses/certifications, providers must submit copies of renewals to the ADSD as applicable.

h. Each provider must cooperate with the ADSD, the DHCFP and/or State or Federal reviews or inspections.

i. Must have the ability to communicate with the recipient, understand the recipient and implement the recipient's PCP.

2. Criminal Background Checks:

A criminal background check is required for all owners, administrators, subcontractors, volunteers and employees who have contact with recipients or access to their financial or personal information.

Refer to MSM Chapter 100 for provider requirements.

All background check information must be maintained on file and available for review, including the initial check and a recheck for each five (5) year period. Refer to NRS 435.220, 435.333, 435.537 and 435.893, NAC 435.515, 435.518, 435.520, 435.537, 435.845, 435.855, 435.860 and 435.893.

3. Required Training for Providers:

a. Employees must have Cardio Pulmonary Resuscitation (CPR) and First Aid training within 30 days of hire and prior to working alone with recipients, if providing direct service. Documentation of training must be kept on file and available for review.

b. Must complete required training and new employee orientation, per ADSD policy, within six months of beginning employment. Documentation of training to be kept on file and available for review.

c. All providers are required to provide annual training to employees on recipient rights; confidentiality; abuse, neglect, exploitation, isolation and abandonment including definitions, signs, symptoms, and prevention; as well as incident and serious occurrence reporting requirements. Providers will also complete established training requirements as directed by the ADSD. Documentation of training must be kept on file and available for review.

d. Supported Living provider employees who administer medication must maintain current certification for Medication Administration pursuant to NAC 435.675. Documentation of training must be kept on file and available for review.

e. Any employee who is likely to utilize restraint procedures in accordance with NRS 433 must maintain current certification in a Crisis Prevention/Intervention training

program approved by the ADSD. Approved training programs require national recognition and evidence of annual review and update of curriculum based on the best legal, behavioral and ethical practices of standards of care. Documentation of training must be kept on file and available for review.

4. Exemptions from Training

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

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

5. Documentation:

Providers must maintain relevant documentation of services provided on one or more documents, including documents that may be created or maintained in electronic format. This documentation must be kept in a manner as to fully disclose the nature and extent of services delivered and must be readily available for review.

The documentation must include:

a. Type of service.

b. Date of service.

c. Name of recipient receiving service.

d. Recipient record number.

e. Name of provider.

f. Full written or electronic signature or initials of the person delivering the service if a signature and corresponding initials are on file with the provider. For electronic signatures, systems and software products must include protections against modification, with administrative safeguards that correspond to policies and procedures of the operating agency. 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. For example, an attendance record must have daily initials and documentation of time in and time out.

g. Number of units of the delivered service during which time the service was provided.

h. Signatures or initials of the recipient must be included on the Jobs and Day Training (JDT) and Residential Support Services logs. If the recipient is unable to provide initials due to a cognitive and/or physical limitation, this will be clearly documented in the Person Centered Plan (PCP).

i. Recipient's living in 24 hour Residential Support settings must have individualized service logs, even if they have shared support hours with roommates living in the home.

j. Providers are required to have copies of side effect information sheets for all medications taken by the recipient on-hand and available for staff.

6. Incidents and Serious Occurrences:

Each Provider~~s~~ must report any recipient incidents to the ADSD. Serious occurrences are to be reported to the ADSD within 24 hours. All other reportable incidents are to be reported to the ADSD within two business days. All Serious Occurrence Reports must be maintained on file by the provider. The ADSD will submit quarterly data to the DHCFP for serious occurrence reports.

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

a. Unplanned hospitalization or ER visit;

b. Injury or fall requiring medical intervention;

c. Physical, verbal, emotional, sexual abuse or sexual harassment;

d. Assault, violence, or threat;

e. Suicide threat or attempt;

f. Criminal activity or legal involvement;

g. Theft or exploitation;

h. Medication error per the ADSD policy;

i. Loss of contact with the recipient;

j. Elopement of a recipient residing in a 24-hour setting;

k. Death of the recipient; or

l. HIPAA violation;

m. Major property damage;

n. Auto accident (involving the recipient);

o. Staff injury/illness/accident requiring medical attention;

p. Environmental incident requiring emergency assistance

q. Death of unpaid caregiver.

7. Notification of Suspected Abuse, Neglect, Exploitation, Isolation, or Abandonment:

State law requires that individuals employed in certain capacities must make a report to the appropriate law enforcement or applicable reporting agency immediately, but in no event later than 24 hours after there is reason to suspect the abuse, neglect, exploitation, isolation, or abandonment of a minor child, vulnerable adult or older individual. The DHCFP requires 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 vulnerable adults' age 18 and over, or any adult 60 or over, Adult Protective Services within the ADSD accepts reports of suspected abuse, neglect or self-neglect, exploitation or isolation.

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

b. Abuse of a Vulnerable Adult or Oder Person- Refer to NRS 200.5091 to 200.50995 regarding elder abuse, exploitation, isolation neglect or abandonment.

c. Vulnerable adult (NRS 200.5091 to 200.50995) is defined as "a person 18 years of age or older who:"

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

2. has one or more physical or mental limitations that restrict the ability of the person to perform the normal ADLs.

8. Complaint Procedure

The Provider must respond to all complaints in a reasonable and prompt manner. The Provider must maintain records that identify the complaint, the date received and the response, outcome and resolution of the incident.

The Provider must investigate and respond in writing to all written complaints within ten calendar days of receipt.

The Provider will provide the recipient written notification of the complaint and its outcome. As appropriate, written notification must also be provided to the Regional Center Service Coordinator.

9. HIPAA, Privacy, and Confidentiality

Refer to MSM Chapter 100 for information on HIPAA, privacy, and confidentiality of recipient records and other Protected Health Information (PHI).

10. The ADSD:

An Interlocal Agreement between the ADSD and the DHCFP is maintained to outline responsibilities of both agencies in the operation and administration of the HCBS for the ID Waiver.

11. Provider Agencies:

a. All employees must have a file which includes reference checks, CPR/First Aid certification and documentation of new employee orientation and ongoing training. All background check information must be maintained in a separate individual employee file.

2103.2B RECIPIENT RIGHTS AND RESPONSIBILITIES

The Recipients are entitled to their privacy; to be treated with respect; and be free from coercion and restraint.

Additionally applicants or recipients must meet and maintain all criteria to be eligible and to remain on the ID Waiver.

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

1. Notify the provider(s) and Service Coordinator of a change in Medicaid eligibility.

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

3. Notify the provider(s) and Service Coordinator of changes in medical status, service needs, address, and location, or changes of designated representative/LRI.

4. Treat all staff and providers appropriately with respect and in a safe manner.

5. Initial and/or sign the provider service documentation logs as applicable, verifying services were rendered unless otherwise unable to perform this task due to intellectual and/or physical limitations.

6. Notify the provider when scheduled visits cannot be kept.

7. Notify the provider and Service Coordinator of missed visits by provider staff.

8. Notify the ADSD and the provider if services are no longer requested or required.

9. Notify the provider and the ADSD Service Coordinator of unusual occurrences, complaints regarding delivery of services or specific staff, or to request a change in caregiver.

10. If applicable, furnish the provider with a copy of their Advance Directives (AD).

11. Not request a provider to work more than the hours authorized in the PCP.

12. Not request a provider to provide service for a non-recipient, family, or household members.

13. Not request a provider to perform services not included in the PCP.

14. Contact the Service Coordinator to request a change of provider.

15. Sign all required forms unless otherwise unable to perform this task due to intellectual and/or physical limitations.

16. Cooperate with all the ADSD meetings and contacts such as phone/face-to-face as per the PCP.

2103.3 DAY HABILITATION

Day Habilitation Services are regularly scheduled activities in a non-residential setting, separate from the recipient's private residence or other residential living arrangement. Services include

assistance with the acquisition, retention, or improvement in self-help, socialization and adaptive skills that include performing ADL's and community living.

Activities and environments are designed to foster the acquisition of skill, building positive social behavior and interpersonal competence, greater independence, and personal choice. Services will include opportunities for volunteer work in community settings and opportunities for community integration through participation in social, recreational, and cultural activities. Services furnished are identified in the recipient's PCP.

Day Habilitation services focus on enabling the recipient to attain or maintain his or her maximum potential and shall be coordinated with any needed therapies in the recipient's person-centered services and support plans, such as physical, occupational, or speech therapy.

Day Habilitation services may also be used to provide supported retirement activities. This may involve alternating schedules to allow for more time throughout the day or supports to participate in hobbies, clubs, and/or activities in the community.

2103.3A COVERAGE AND LIMITATIONS

1. Recipients who receive Day Habilitation services and supports may have two or more types of non-residential services.– However, different types of non-residential habilitation services may not be billed during the same time period of the day.

2. Day Habilitation may not provide for the payment of services that are vocational in nature (i.e. for the primary purpose of producing goods or performing services).

3. Documentation is maintained in the file of each recipient receiving Day Habilitation that the service is not available under a program funded by Section 110 of the Rehabilitation Act of 1973 or Individuals with Disabilities Education Improvement Act (IDEA) (20 U.S.C. 1401 et seq.).

2103.3B DAY HABILITATION PROVIDER RESPONSIBILITIES

Refer to MSM Section 2103.2A.

2103.3C RECIPIENT RIGHTS AND RESPONSIBILITIES

Refer to MSM Section 2103.2B.

2103.4 RESIDENTIAL SUPPORT SERVICES

Residential Support Services are designed to ensure the health and welfare of the recipient, as well as the welfare of the community at large, through protective oversight and supervision activities

in addition to support to assist in the acquisition, improvement, retention, and maintenance of the skills necessary for recipients to successfully, safely, and responsibly reside in their community.

Residential Support Services are provided throughout the course of normal ADLs, as well as in specialized training opportunities outlined in the recipient's PCP. These services are individually planned and coordinated, assuring the non-duplication of services with other Medicaid State Plan Services. PCP teams may identify priority areas to address through habilitation plans, however that does not limit additional supports that a person may need to live in the community. These additional supports do not require habilitation plans.

Residential Support Services staff are trained and responsible for implementing the Individual Habilitation Plans, goals and objectives, and other service supports related to residential and community living. These supports include but are not limited to:

A. the facilitation of personal care;

B. ADLs and IADLs;

C. supports for health and welfare needs;

D. effective communication skills;

E. community inclusion

F. the development of natural support networks;

G. mobility training;

H. survival and safety skills;

I. support and teaching of interpersonal and relationship skills;

J. making choices and problem-solving skills;

K. community living skills;

L. social and leisure skills;

M. money management skills;

N. support and skill training related to health care needs, to include medication management.

Residential Support Services emphasize positive behavioral strategies, including interventions and supervision designed to maximize community inclusion while safeguarding the recipient and

general public. The Service Coordinator will ensure the recipient has freedom in their residential setting. Services also support exercising recipient's rights and protect against rights violations and infringements without due process.

Intermittent Supported Living Services are services provided by an individual or organizational provider to recipients residing in their own homes who do not require one-on-one supervision and/or 24-hour care.

A Shared Living Arrangement is an arrangement in which an individual with a disability, and a person, couple or family choose to live together in an integrated community neighborhood which provides Residential Support Services through an intermittent Supported Living Arrangement (SLA).

Twenty-four hour Supported Living Services are Residential Support Services provided up to 24 hours per day by an organizational provider. These services are delivered within homes in integrated neighborhood settings.

Residential Support Services cannot duplicate the scope and nature of Medicaid State Plan Personal Care Services (PCS). Services must be coordinated to ensure there is no duplication. Waiver services must be authorized in the recipient's PCP.

2103.4A COVERAGE AND LIMITATIONS

1. Residential Support Services staff receives training and are responsible for implementing PCPs, goals, objectives, and service supports related to residential living and community life.

   These services include but are not limited to:

   a. the participation in the development of the PCP.

   b. adaptive skill development.

   c. facilitation of personal care and ADLs.

   d. facilitation of community inclusion.

   e. facilitation of IADLs to include teaching community life skills; interpersonal and relationship skills; building of natural support networks; choice making skills; social and leisure skills; budgeting and money management skills.

f. providing assistance with medication administration by a staff certified in an ADSD approved Medication Program. Verification of certification must be maintained in the employee files.

g. providing assistance with support and skill training in health care needs.

h. facilitation of mobility training, survival and safety skills.

2. Residential Support Services may be provided on a continuum of service delivery model ranging from intermittent up to 24-hour SLA, as determined by the PCP team. Residential Support Services are provided in either the service recipient's natural family home or in a non-provider owned home or apartment; owned or leased in the service recipient's name or on behalf of the service recipient, with the exception of approved Shared Living services and provider owned homes that have been approved by the Regional Center. The provider is required to have a lease with each service recipient living in a provider owned home. Residential Support Services are provided in integrated settings within community residential neighborhoods. In 24-hour SLA, protective oversight hours must be shared with other recipients in the home unless clear documentation exists that shows a need for one-on-one supervision due to health and safety needs of the recipient which are supported in the PCP and approved by the Regional Center Program Manager.

3. Under this service category, the responsibility for the living environment rests with the service agency and encompasses a variety of SLAs:

a. Residential Support Services in a 24-hour setting are limited to four recipients unless otherwise authorized by the Regional Center Program Manager.

b. SLAs are limited to two service recipients residing in one home, unless otherwise authorized by the Regional Center Program Manager.

Individual SLA homes do not require state licensure; however, individual providers and provider agencies must be certified by the ADSD in order to render services to ID Waiver recipients.

2103.4B PROVIDER RESPONSIBILITIES

Refer to MSM 2103.2A, in addition to the provider responsibilities listed:

1. Providers must ensure the recipient has the freedom to furnish and decorate their living area to their liking within the lease or other agreement.

2. The Provider will ensure the setting is physically accessible to the recipient. The Provider will ensure the units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.

3. Settings where landlord/tenant laws do not apply, the provider must ensure that a written residential agreement is in place for the HCBS Waiver recipient and that it provides comparable protections as those under the jurisdiction's landlord/tenant law.

4. Exceptions to the above must be supported by assessed need and clearly justified and documented in the PCP.

2103.4C RECIPIENT RIGHTS AND RESPONSIBILITIES

Refer to MSM 2103.2B.

2103.5 PREVOCATIONAL SERVICES

Prevocational Services should enable recipients to attain the highest level of vocation in the most integrated setting and by matching the recipient's interests, strengths, priorities, abilities, and capabilities to the job while following applicable Federal wage guidelines. The services are intended to develop and teach general skills. Examples include but are not limited to: ability to communicate with supervisors, co-workers and customers in the workplace setting; generally accepted workplace conduct and dress; an ability to follow directions; an ability to complete tasks; workplace problem solving skills and strategies; and workplace safety and mobility training.

Prevocational Services provides for learning and work experience, which may include volunteer work, where a recipient can develop general, non-job or task-specific strengths and skills that contribute to employability in paid employment within integrated community settings. Services are expected to occur over a defined period of time and with specific outcomes to be achieved, as identified in the recipient PCP. The services are designed to create a path to integrated, community-based employment for which a recipient is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Recipients receiving Prevocational Services must have employment-related goals in their PCP; the general habilitative activities must be designed to support such employment goals Competitive, integrated employment in the community for which a recipient is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities, considered to be the optimal outcome for Prevocational Services.

2103.5A COVERAGE AND LIMITATIONS

The Prevocational Services provided under this waiver are not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or Section 602(16) and (17) of the IDEA (20 U.S.C. 1401(16 and 17)). Documentation will be maintained in the file of each recipient receiving Prevocational Services that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

1. Recipients who receive Prevocational Services may include two or more types of non-residential support services; however, different types of non-residential support services may not be billed during the same time period of the day.

2103.5B PROVIDER RESPONSIBILITIES

Refer to MSM Section 2103.2A.

2103.5C RECIPIENT RIGHTS AND RESPONSIBILITIES

Refer to MSM Section 2103.2B.

2103.6 SUPPORTED EMPLOYMENT

Supported Employment Services are individualized and may include any combination of the following services: Vocational job related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, benefit supports, training and planning, transportation training, asset development and career advancement services and other workplace support services including services not specifically related to job skill training that enable the recipient to be successful in integrating into the job setting.

There are two sub-categories of Supported Employment – Individual Supported Employment and Small Group Supported Employment.

A. Individual Supported Employment

Individual Supported Employment is for recipients who need intensive ongoing supports to obtain and maintain a job that meets their personal and career goals in competitive, customized employment, or self-employment, in an integrated work setting within the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Individual Supported Employment services do not include payment for supervision, training, support, or

adaptations typically available to other workers without disabilities in similar positions in the business. Individual Supported Employment services also do not include supports needed for unpaid, volunteer opportunities.

One approach to individual supported employment is Customized Employment. Customized Employment means individualizing the employment relationship between employees and employers in ways that meet the needs of both. It is based on an individualized determination of the strengths, needs and interest of the recipient, and is also designed to meet the specific needs of the employer. Customized Employment assumes the provision of reasonable accommodations and support necessary to perform the function of a job that is individually negotiated and developed.

B. Small Group Supported Employment

Small Group Employment Supports are services and training activities provided in regular business, industry, and community settings of two to eight workers with disabilities. Examples include mobile crews which employ small groups of recipients in integrated employment in the community with the goals of sustained paid employment and work experience leading to further career development and individual integrated community-based employment for which the recipient is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Small Group Supported employment services do not include payment for supervision, training, support, or adaptations typically available to other workers without disabilities in similar positions in the business. Small Group Employment services also do not include supports needed for unpaid, volunteer opportunities.

The desired outcome of Supported Employment services is sustained paid employment and work experience leading to further career development and individual integrated community-based employment for which the recipient is compensated at or above the minimum wage, but not less than the customary wage and level benefits paid by the employer of the same or similar work performed by individuals without disabilities.

2103.6A COVERAGE AND LIMITATIONS

1. When Supported Employment services are provided at a work site in which individuals without disabilities are employed, payment will be made only for the adaptations, supervision and training required by recipients as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

2. Supported Employment furnished under the ID Waiver may not include services available under a program funded under Section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17), of the Individuals with Disabilities Education Act (IDEA) (20 U.S.C 1401 (16 and 17).

3. Supported Employment services do not include supports needed for unpaid, volunteer.

4. Federal Financial Participation (FFP) will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

   a. Incentive payments made to an employer to encourage or subsidize the employer's participation in a Supported Employment services;

   b. Payments that are passed through to users of Supported Employment services; or

   c. Payments for vocational training that is not directly related to a recipient's Supported Employment services.

5. Supported Employment services do not include facility-based work settings, or other similar types of vocational services furnished in specialized facilities that are not a part of the general workforce.

6. Recipients who receive Supported Employment services may receive two or more types of non-residential support services; however, different types of non-residential support services may not be billed during the same period of the day.

2103.6B PROVIDER RESPONSIBILITIES

Refer to MSM Section 2103.2A.

2103.6C RECIPIENT RIGHTS AND RESPONSIBILITIES

Refer to MSM Section 2103.2B.

2103.7 BEHAVIORAL CONSULTATION, TRAINING AND INTERVENTION

Behavioral Consultation, Training and Intervention Services provide behaviorally based assessment and intervention for recipients, as well as support, training, and consultation to family members, caregivers, paid residential support staff, or jobs and day training staff. This service also includes participation in the development and implementation of the PCP and/or Positive Behavior Support Plans, necessary to improve a recipient's independence and inclusion in their community, increase positive alternative behaviors, and/or address challenging behavior. These services are

not covered under the State Plan and are provided by professionals in Psychology, Behavior Analysis and related fields.

2103.7A COVERAGE AND LIMITATIONS

1. Behavioral Consultation, Training and Intervention may be provided in the recipient's home, school, workplace, and in the community. The services include:

   a. functional behavioral assessment and an assessment of the environmental factors that are precipitating a problem behavior;

   b. development of Behavior Support Plan in coordination with the team members;

   c. consultation and/or training on how to implement positive behavior support strategies and/or Behavior Support Plan;

   d. consultation or training on data collection strategies to monitor progress.;

   e. monitoring of recipient and the provider(s) in the implementation and modification of the support plan, as necessary;

   f. Participation in the PCP;

   g. Team meeting and medical appointments to provide resources information and recommendations, as necessary; and

   h. Providing a monthly summary of progress.

Behavioral Consultation, Training and Intervention may not exceed $5,200.00 per year per recipient. Written authorization by the Regional Center is required for amounts in excess of the limit.

2103.7B PROVIDER RESPONSIBILITIES AND QUALIFICATIONS

1. In addition to the provider responsibilities listed in MSM Section 2103.2A:

   a. Employees of behavioral provider agencies and individual providers have:

      1. Professional holding Bachelor's level licensure and/or certification per NRS 437; or has a Bachelor's degree in psychology, special education or closely related field plus at least one year professional clinical experience using behavior intervention and functional assessment procedures as well as developing, implementing and monitoring of behavior support plans in applied setting; or

2. Professional holding Master's level licensure and/or certification per NRS 437; or has a Master's degree in psychology, special education or closely related field with expertise in functional assessment and the provision of positive behavioral supports.

b. Experience working with individuals with intellectual disabilities or developmental disabilities is preferred.

2103.7C RECIPIENT RIGHTS AND RESPONSIBILITIES

Refer to MSM Section 2103.2B.

2103.8 COUNSELING SERVICES

Counseling Services provide assessment/evaluation, consultation, therapeutic interventions, support and guidance for recipients and/or family members, caregivers, and team members, which are not covered by the Medicaid State Plan and which improve the recipient's personal adaptation and inclusion in the community. This service is available to recipients who have intellectual and/or developmental disabilities and provides problem identification and resolution in areas of interpersonal relationships, community participation, independence, and attaining personal outcomes, as identified in the recipient's PCP.

Counseling Services are specialized and adapted in order to accommodate the unique complexities of enrolled recipients and may include;

A. consultation with team members, including family members, support staff, service coordinators and other professionals comprising the participant's support team;

B. individual and group counseling services;

C. assessment/evaluation services;

D. therapeutic interventions strategies;

E. risk assessment;

F. skill development;

G. psycho educational activities;

H. participating in PCP Team meetings and appointments to provide resource information and recommendations, as necessary; and

I. providing a monthly summary of progress.

Counseling services are provided based on the recipient's need to assure his or her health and welfare in the community and enhance success in community living.

2103.8A COVERAGE AND LIMITATIONS

Counseling services may not exceed $1,500.00 per year per recipient. Written authorization by the Regional Center is required for amounts in excess of the limit.

2103.8B PROVIDER RESPONSIBILITIES AND QUALIFICATIONS

1. In addition to the provider responsibilities listed in MSM Section 2103.2A:

   a. Providers must have graduated from an accredited college or university with a Master's degree in a two year curriculum in counseling, marriage and family therapy, psychology, social work or a closely related academic field. A closely related field is licensed by the State of Nevada by appropriate categories; or

   b. A graduate level intern who is enrolled in a Master's level program at an accredited college or university that provides at least two year curriculum in counseling, marriage and family therapy, psychology, social work or a closely related academic field or doctor level program in a clinical field; and are supervised by a licensed clinician or mental health counselor.

   c. Professional experience in a setting serving individuals with intellectual disabilities is preferred.

2103.8C RECIPIENT RIGHTS AND RESPONSIBILITIES

Refer to MSM Section 2103.2B.

2103.9 RESIDENTIAL SUPPORT MANAGEMENT

Residential Support Management is designed to ensure the health and welfare of recipients receiving Residential Support Services from agencies. This service is intended to ensure the supports are planned, scheduled, monitored, and implemented according to the recipient's preferences and needs depending on the frequency and duration of approved services.

2103.9A COVERAGE AND LIMITATIONS

1. Residential Support Management staff will assist the recipient in managing their supports

within the home and community settings. This service includes:

a. assisting the recipient to develop one's goal(s);

b. scheduling and attending interdisciplinary meetings;

c. develop habilitation plans specific to Residential Support Services, as determined in the recipient's PCP and training residential support staff in implementation and data collection;

d. assisting the recipient to apply for and obtain community resources and benefits such as Medicaid, Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Housing and Urban Development (HUD), Supplemental Nutrition Assistance Program (SNAP), housing, etc.;

e. assisting the recipient in locating residences;

f. assisting the recipient in arranging for and effectively managing community resources and informal supports;

g. assisting the recipient to identify and sustain a personal support network of family, friends, and associates;

h. providing problem solving and support with crisis management;

i. supporting the recipient with budgeting, bill paying, and with scheduling and keeping appointments;

j. observing, coaching, training and providing feedback to direct service staff to ensure they have the necessary and adequate training to carry out the supports and services identified in the PCP;

k. following up with health and welfare concerns and remediation of deficiencies;

l. completing required paperwork on behalf of the recipient (as needed);

m. making home visits to observe the recipient's living environment to assure health and welfare; and

n. providing information to the Service Coordinator (Targeted Case Manager) and support team members to allow evaluation and assurance that support services provided are those defined in the PCP and are effective in assisting the recipient to

reach his or her goals.

Residential Support Managers must work collaboratively with the recipient's Service Coordinator as well as other support team members. Residential Support Management services are different from Targeted Case Management as the Service Coordinator is responsible for the development of the PCP, which is the overall HCBS support plan, in consultation with the PCP Team.

2103.9B PROVIDER RESPONSIBILITIES AND QUALIFICATIONS

In addition to provider listed in 2103.2A, Residential Support Managers must have:

1. A High School Diploma or equivalent and two years' experience providing direct service in a human services field and remain under the direct supervision/oversight of a Qualified Intellectual Disabilities Professional (QIDP) or its equivalent; or

2. Completion of a Bachelor's degree from an accredited college or university in psychology, special education, counseling, social work, or closely related field and one year of experience meeting the qualification of a QIDP.

2103.9C RECIPIENT RIGHTS AND RESPONSIBILITIES

Refer to MSM Section 2103.2B.

2103.10 NON-MEDICAL TRANSPORTATION

Non-Medical Transportation service are offered to enable recipients to gain access to community activities. Non-Medical Transportation service allows recipients to engage in normal day-to-day non-medical activities such as going to the grocery store or bank, participating in social and recreational events or attending a worship service; activities are not all inclusive. Whenever possible, family, neighbors, friends, or community agencies should provide this service without charge.

2103.10A COVERAGE AND LIMITATIONS

1. This service will not duplicate or impact the amount, duration and scope of the Medical Transportation benefit provided under the Medicaid State Plan. Refer to MSM Chapter 1900 for more information regarding the coverage and limitations of State Plan Medical Transportation.

2. Non-Medical Transportation services under this waiver must be described or identified in the recipient's PCP before the service is utilized. The use of Non-Medical Transportation must be summarized in the provider's quarterly progress report.

3. Non-Medical Transportation fees cannot exceed $100.00 per month per recipient.

2103.10B PROVIDER RESPONSIBILITIES

In addition to provider responsibilities listed in 2103.2A, providers must have:

1. A valid Nevada Driver's License and provide verification of safe driving record and proof of driver's liability insurance.

2. Evidence of vehicle safety inspection completed prior to transporting recipient's and completion of ongoing periodic vehicle safety inspections. Providers are responsible for obtaining vehicle safety inspections and providing them to the ADSD upon request.

2103.10C RECIPIENT RIGHTS AND RESPONSIBILITIES

Refer to MSM Section 2103.2B.

2103.11 NURSING SERVICES

There are three components of Nursing Services: Medical Management, Nursing Assessment, and Direct Services, (over and above State Plan).

1. Medical Management

These services will be provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) licensed in the state. Services are geared toward the development of health services support plans; training of direct support staff or family members to carry out treatment; monitoring of staff knowledge and competence to improve health outcomes; assistance with revision of health support plans in response to new or revised treatment orders or lack of positive outcomes of current supports by staff; monitoring/ assessment of the recipient's condition in response to current health supports provided; and as needed assistance with referrals to other medical providers. This service includes professional observation and assessment, individualized program design and implementation, training of recipients and family members, consultation with caregivers and other agencies, and monitoring and evaluation of planning and service outcomes. The functions outlined for this service differs from case management in that this service relates directly to the medical needs of the individual.

In addition, nurses may attend PCP team meetings and physician visits as needed to provide advocacy, resource information and recommendations to team and treating physicians in order to facilitate health supports.

2. Nursing Assessment

This service will be completed by a RN to identify the needs, preferences, and abilities of the recipient. The assessment includes: an interview with the recipient; and/or their designated representative/LRI, an observation by the nurse to consider the symptoms and signs of condition, verbal and nonverbal communication skills, medical and social history, medication and any other information available.

The nurse will assess vital signs, skin color and condition, motor and sensory nerve function, reproduction, dentition, height, nutrition, rest, sleep patterns, physical activities, elimination, and level of consciousness. Additionally, the following social and emotional factors will be assessed which include religion, occupation, attitudes on health care, mood, emotional tones, family ties and responsibility. The assessment is extremely important because it provides recommendations for medical and mental health care and follow-up which are shared with the recipient's team for review and inclusion in the PCP. Nursing assessments may be performed and completed upon approved referral and authorization of the service coordinator. Assessments are completed by a RN and provide the basis for recommendations for medical and mental health care and follow-up, which are shared with the person's team for review and inclusion in the individual's support plan.

3. Direct Services

This service provides routine medical and health care services that are integral to meeting the daily needs of participants. This includes the routine administration of medication by nurses tending to the needs of participants who are ill and providing care to participants who have ongoing medical needs. Direct skilled nursing services are intended to be provided by an RN or LPN in a community setting, including home or work, as described and approved in the recipient's PCP. LPNs must be under the supervision of a RN licensed in the state. Services include skilled medical care that is integral to meeting the daily medical needs of recipient. These services are intended to allow individuals under this waiver to live safely within an integrated community setting.

Services are limited to those that only a licensed professional can provide versus non-skilled care that unlicensed staff can provide such as, activities of daily living.

Skilled services include, but are not limited to: medication administration, wound care, nasogastric or gastronomy tube feeding, ostomy care, tracheotomy aspiration care, and catheter care, only when the procedure can be performed safely by a RN or LPN.

2103.11A COVERAGE AND LIMITATIONS

1. Nursing Services must be provided within the Scope of the Nevada Nurse Practice Act.

2. Nursing Services must be provided by an RN or LPN under the supervision of an RN who is licensed to practice as a nurse in the State of Nevada.

3. Nursing Services under the ID Waiver must include nursing progress notes and summaries on all nursing activities.

4. Nursing Services may be provided in the recipient's home, work site, or in other community settings as described in the PCP.

5. Nursing Services provided in this waiver will not duplicate the Nursing Services covered under the Medicaid State Plan.

2103.11B PROVIDER RESPONSIBILITIES AND QUALIFICATIONS

In addition to provider responsibilities listed in 2103.2A providers must be:

1. An RN in accordance with NRS 632 licensing requirements; or

2. An LPN under the supervision of an RN in accordance with NRS 632 licensing requirement.

2103.11C RECIPIENT RIGHTS AND RESPONSIBILITIES

Refer to MSM Section 2103.2B.

2103.12 NUTRITION COUNSELING SERVICES

Nutrition Counseling Services include assessment of the recipient's nutritional needs, development and/or revision of recipient's nutritional plan, nutritional counseling and nutritional intervention, observation and technical assistance related to successful implementation of the nutritional plan. These services include:

a. Nutritional training, education and consultation for recipients and their families or support staff involved in the day-to-day support of the recipient;

b. Completing comprehensive assessment of nutritional needs;

c. Developing, implementing and monitoring of nutritional plan incorporated in the PCP, including updating and making changes in the PCP as needed;

d. Assisting in menu planning and healthy menu options; and

e. Providing monthly case notes on nutritional activities and summaries of progress on the nutritional plan.

These waiver-covered nutritional duties are above and beyond those approved and covered under Medicaid State Plan Services.

2103.12A COVERAGE AND LIMITATIONS

This service is limited to $1,300.00 per year, per recipient. This service does not include the cost of meals or food items.

2103.12B PROVIDER ADDITIONAL RESPONSIBILITIES AND QUALIFICATIONS

In addition to the provider responsibilities/qualifications listed in MSM Section 2103.2A, providers must be:

1. A registered Dietician as certified by the American Dietetic Association.

2. Licensed to practice in the State of Nevada.

2103.12C RECIPIENT RIGHTS AND RESPONSIBILITIES

Refer to MSM Section 2103.2B.

2103.13 CAREER PLANNING

Career Planning is a person-centered, comprehensive employment planning and support service that provide assistance for recipients to obtain, maintain, or advance in competitive employment or self-employment. It is time limited and focuses on engaging a recipient in identifying a career direction and developing a plan for achieving integrated employment at or above minimum wage.

Career Planning includes activities that are primarily directed at assisting a recipient with identification of an employment goal and creating a plan to achieve this goal that are associated with performing competitive work in community integrated employment. This can be achieved by job exploration, job shadowing, informational interviewing, assessment of interests and labor market research.

The providers coordinate, evaluate and collaborate with recipients, designated representative/LRI, support team, employers and others who can assist with discovering recipients' skills, abilities, interests, preferences, conditions and needs. This support and evaluation should be provided to the maximum extent possible in the presence of the recipient and should be conducted in the

community, but completion of activities in the home or without the presence of the recipient should not be precluded.

A. If a waiver recipient is employed, career planning may be used to explore other competitive employment career objectives which are more consistent with the person's skills and interests, or to explore advancement opportunities in his or her chosen career.

B. Career Planning should be reviewed and considered as a component of a recipient's person-centered services and support plan, no less than annually, more frequently as necessary, or as requested by the recipient.

C. These services should be designed to support successful employment outcomes consistent with the recipient's goals.

D. Career Planning may include social security benefits support, training, consultation and planning as well as assessments for the use of assistive technology in the workplace to increase independence.

E. The setting for the delivery of services must be aligned with the individualized need and that which is most conducive in developing a career objective and a career plan.

The outcome of this service is documentation of the individual's stated career objective and career plan used to guide individual employment support. Services include planning for sufficient time and experiential learning opportunities to allow for appropriate exploration, assessment and discovery processes for learning about career options, as well as the participant's skills and interests. Career Planning may include informational interviewing, job tours, job shadowing, community exploration, community and business research, benefit supports, job preference inventories, situational and community-based assessments, job sampling, training and planning, as well as assessments for the use of assistive technology in the workplace to increase independence.

2103.13A COVERAGE AND LIMITATIONS

1. The PCP may include two or more types of non-residential habilitation services. However, different types of non-residential habilitation services may not be billed simultaneously. If a waiver recipient is receiving Pre-Vocational Services or Day Habilitation Services, Career Planning may be used to develop additional learning opportunities and career options consistent with the recipient's skills and interest.

2. Career Planning will be limited to 216 hours within a six-month time period each year per recipient. The six-month periods may not be provided consecutively.

3. Career Planning furnished under the waiver may not include services available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401 (16 and 17).

2103.13B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in MSM Section 2103.2A, providers of Career Planning must have:

1. Experience in working with individuals with intellectual and developmental disabilities providing employment service and job development.

2. Knowledge of person-centered career planning, job analysis, supported employment services, situational and community-based assessments, best practices in customized employment, and knowledge of the business needs of an employer.

3. A Valid Nevada Driver's License. Must also have access to an operational and insured vehicle and be willing to use it to transport recipients. (Providers will bill Career Planning unit rate for time spent transporting, this is not a separate rate); And

4. Evidence of vehicle safety inspection completed prior to transporting recipient's and completion of ongoing periodic vehicle safety inspections. Providers are responsible for obtaining safety inspections and providing them to the ADSD upon request.

2103.13C RECIPIENT RIGHTS AND RESPONSIBILITIES

Refer to MSM Section 2103.2B.

2103.14 INTAKE PROCEDURES

A. WAIVER REFERRAL AND PLACEMENT ON THE WAIT LIST

1. A referral or inquiry for the waiver may be made by a potential applicant or by another party on behalf of the potential applicant by contacting the local ADSD Regional Center. The Regional Center staff will discuss waiver services, including eligibility requirements with the referring party or potential applicant.

2. The Service Coordinator must conduct a LOC screening to verify eligibility for the wait list.

NOTE: If the applicant does not meet an LOC, they will receive a Notice of Decision (NOD) which includes the right to a fair hearing.

3. All applicants who meet waiver criteria must be placed on the statewide waiver wait list by priority and referral date. The following must be completed before placement on the wait list:

   A. The applicant must meet LOC criteria for placement in an ICF/IID.

   B. The applicant must require at least one ongoing waiver service.

   C. The applicant must meet criteria for an intellectual or developmental disability.

Applicants will be sent a NOD indicating "no slot available. The ADSD will notify the DHCFP LTSS Unit when no slot is available. The applicant will remain on the waiting list until a waiver slot is available.

The allocation of waiver slots is maintained with the ADSD. As waiver slots become available, ADSD determines how many slots may be allocated.

B. WAIVER SLOT ALLOCATION

Once a waiver slot is allocated by the ADSD, the applicant will be processed for the waiver.

The procedure used for processing an applicant will be as follows:

1. The ADSD Service Coordinator will schedule a face-to-face visit with the applicant to complete the full waiver assessment to include diagnostic data, LOC determination, and will obtain all applicable forms, including but not limited to the Authorization for Release of Information.

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

   The ADSD Service Coordinator will inform the applicant and/or designated representative/LRI that, pursuant to NRS 232.357, the Divisions within the Nevada Department of Health and Human Services (DHHS) may share confidential information between themselves without a signed authorization for release of information.

   The Service Coordinator will provide an application to apply for Medicaid benefits through DWSS if the applicant does not have these benefits already in place. The

applicant is responsible for completing the application and submitting all requested information to DWSS. The Service Coordinator will assist upon request.

2. The applicant/recipient will be given the right to choose waiver services in lieu of placement in an ICF/IID. If the applicant/recipient and/or designated representative/LRI prefers placement in an ICF/IID, the service coordinator will assist the applicant/recipient in arranging for facility placement.

3. The applicant/recipient will be given the right to request a hearing if not given a choice between HCBS Waiver and ICF/IID placement.

4. When the applicant/recipient is approved by the ADSD for the ID Waiver services, the following will occur:

   a. A team meeting is held, and a written PCP is developed in conjunction with the recipient and the PCP Team to determine specific service needs and to ensure the health and welfare of the recipient. The applicant/recipient and/or designated representative/LRI and provider(s) must sign and date the PCP. Interim PCP's, unsigned by the applicant/recipient and/or designated representative/LRI and the provider(s), may be authorized for up to 60 days from the PCP development meeting.

      Note: Applicant/recipients already receiving services via the ADSD State General Funds will already have a PCP in place.

   b. The applicant/recipient, the applicant/recipient's family, or the designated representative/LRI, providers, and participants of the applicant/recipient's choice are included in the development of the PCP.

   c. Applicants/recipients will be given the free choice of all qualified available Medicaid providers of each Medicaid covered service included in the written individual support plan. Current PCP must be given to all service providers and kept in the recipient's record.

   d. All forms must be complete with signatures and/or initials and dates by the applicant/recipient and/or designated representative/LRI and provider(s), where required. Electronic signatures are acceptable, as pursuant to NRS 719, on forms that require a signature.

   e. The ADSD will forward a completed waiver packet requesting to add a benefit plan to the DHCFP LTSS Unit.

1. The HCBS Waiver Eligibility Status form will be sent by the DHCFP Central Office Waiver Unit to the ADSD Service Coordinator.

2. The ADSD is responsible for notifying the DWSS of approval to coordinate waiver slot allocation.

3. The DWSS is responsible for notifying the ADSD of the applicants' status, to initiate~~d.~~ waiver services.

C. SUPPORT PLAN DEVELOPMENT

Developmental Services uses a person-directed planning process. Assessment information assists the team with identifying barriers to reaching the person's vision, desired outcomes, and support needs. Goals related to reaching the vision are developed based on the person's desired life outcomes, as well as any needs for maintaining appropriate health and welfare. This information is provided to the person-centered team for plan development at the PCP meeting. This process provides direction for the identification of goals and assures that the meeting focuses on the participant and his or her priorities, preferences, and perspective.

The PCP is developed utilizing applicable assessments that may include a social assessment, health assessment, risk assessment, or self-medication administration assessment tool.

The support plan is inclusive of the services and supports that are provided to meet the assessed needs of the participant. The service coordinator is responsible for understanding all services provided to the service recipient, gathering assessment, information, developing the PCP based on team recommendations, facilitating plans for any necessary referrals, and monitoring all services, as part of the support plan implementation. The support plan also identifies the priority areas to be addressed based upon the person-centered planning process. The PCP will identify which priority areas of support require habilitation plans. Additional supports, including general supervision, can be provided as needed to assist the individual with their daily life living in the community without the need for habilitation plans.

D. EFFECTIVE DATE FOR WAIVER SERVICES

The effective date for waiver services approval is the completion date of all the intake forms, or the waiver eligibility determination date by the DWSS, whichever is later. If the applicant is in an institution, the effective date cannot be prior to the date of discharge from the institution.

Waiver services will not be backdated beyond the first of the month in which the waiver eligibility determination is made by the DWSS.

E. SERVICE COORDINATION

Service Coordination is provided under the Medicaid State Plan Targeted Case Management service. This is an integral part of the management of the ID Waiver.

Refer to MSM Chapter 2500 for allowable activities under Targeted Case Management.

F. WAIVER COST

The 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 Medicaid State Plan that would have been made in that fiscal year, had the waiver not been granted.

2103.15 PERMANENT CASE FILE

A. For each approved ID Waiver recipient, the Service Coordinator must maintain a permanent record that documents services provided under the ID Waiver. The service provider is also required to maintain their billing documents and service records.

B. These records must be retained for six years from the date the last claim is paid.

2103.16 SERVICE COORDINATOR RECIPIENT CONTACTS

A. Recipient Contact

1. The Service Coordinator must have monthly contact with each waiver recipient, or a recipient's designated representative/LRI, or the recipient's Supported Living or Jobs and Day Training provider. The contact must be sufficient to address health and safety needs of the recipient, needed support plan changes, recipients' goals and satisfaction with services and supports. At a minimum, there must be a face-to-face visit with each recipient quarterly.

2. During quarterly contacts, the Service Coordinator will monitor whether the habilitation plans are meeting identified goals and provide any necessary follow up on needs or concerns.

a. The Service Coordinator must show due diligence to hold the established contacts as outlined in the PCP and every attempt to contact the recipient must be documented. At least three attempts must be completed on separate days within the quarter, if no response is received after the 3rd 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.

b. When DHCFP is conducting a review of a recipient and the Service Coordinator has clearly documented the above steps were attempted during any given quarter wherein a quarterly contact was required, DHCFP shall waive that quarterly contact requirement.

B. Reassessment

1. Recipients must be reassessed at least annually within the same month. The recipient and provider(s) must sign and date the PCP. Interim PCP's, unsigned by the recipient and provider(s), may be authorized for up to 60 days.

2. The recipient must also be reassessed when there is a significant change in his/her condition.

3. The number of hours specified on each recipient's Service Authorization for each specific service, are considered the maximum number of hours allowed to be provided by the provider and paid by the ADSD and the DHCFP, unless the Service Coordinator has approved additional hours due to a temporary condition or circumstances. Providers are allowed to provide fewer services than stated on the Service Authorization if the reason for providing less service is adequately documented.

4. When the recipient's service needs increase, due to a temporary condition or circumstance, the Service Coordinator must thoroughly document the increased service needs in their case notes. The PCP 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.

5. Residential Support Management hours are defined in the PCP. A temporary increase in the residential support management hours for the recipient must receive prior authorization from the ADSD, within the month of the temporary increase, and be justified based on health, safety and welfare concerns. If an increase is warranted to exceed a 30-day period, there must be a reassessment based on thorough documentation in the Residential Support Managers case notes reflecting

the health, safety and welfare concerns and the Service Authorization must be revised.

a. Reassessment Procedures

During the reassessment process, the Service Coordinator must:

1. Re-affirm the recipient meets the waiver criteria outlined in Section 2103.1.

2. Re-assess the recipient's ability to perform ADLs and IADLs, his/her medical and mental status and support systems.

3. Re-evaluate the services being provided and progress made toward the goal(s) stated in the PCP.

4. Develop a revised PCP.

5. Re-assess the recipient's LOC.

6. Inform recipients about their rights, including the right to be free from abuse, neglect, exploitation, isolation and abandonment.

2103.17 BILLING PROCEDURES

The State assures that claims for payment of ID Waiver services are made only when a recipient is Medicaid eligible and only when the service is included in the approved PCP plan.

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

2103.18 DHCFP ANNUAL REVIEW

The DHCFP (administrative authority) conducts an annual program review of the ID Waiver operated by the ADSD to assess policy adherence, recipient quality of life, and the health and welfare of recipients receiving waiver services. The State must operate this waiver in accordance with certain "assurances" identified in Federal regulations. CMS has designated waiver assurances and sub assurances that states must include as part of an overall quality improvement strategy, which are:

1. The State demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating a recipient's LOC consistent with care

provided in a hospital, NF or ICF/IID.

a. An evaluation for LOC is provided to all recipients for whom there is reasonable indication that services may be needed in the future.

b. The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine initial recipient LOC.

2. Support Plan: The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of supportive service plans for waiver recipients.

a. Support Plans address recipients assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means as determined by the PCP team through the person-centered planning process.

b. Support Plans are updated/revised at least annually or when warranted by changes in the waiver recipient's needs.

c. Services are delivered in accordance with the support plan, including the type, scope, duration, and frequency specified in the support plan.

3. Qualified Providers: The State demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

a. The State verifies that providers initially and continually meet required licensure and /or certification standards and adhere to other standards prior to their furnishing waiver services.

b. The State implements its policies and procedures for verifying that training is provided in accordance with State requirements and the approved waiver.

4. Health and Welfare: The State demonstrates it has designed and implemented an effective system for assuring wavier recipient health and welfare.

a. The State demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation, isolation and unexplained death.

b. The State demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the

extent possible.

c. The State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

d. The State assures overall health and safety and monitors these assurances based on the responsibility of the service provider as stated in the approved waiver.

5. Financial Accountability: The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver.

a. The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

b. The State provides evidence that rates remain consistent with the approved rate methodology through the five-year waiver cycle.

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

The annual review is conducted using the above assurances and sub assurances as well as state specified performance measures identified in the approved ID waiver in order to evaluate the operation of the waiver.

Providers must cooperate with the DHCFP's annual review process.

2103.19 MEDICAID PROVIDER ENROLLMENT PROCESS

1. All providers should refer to the MSM Chapter 100 for enrollment procedures.

2. All providers must comply with all the DHCFP and ADSD enrollment requirements, provider responsibilities/qualifications, the DHCFP and ADSD provider agreement and limitations set forth in this chapter.

3. Provider non-compliance with all or any of these stipulations may result in the DHCFP's decision to exercise its right to terminate the provider's contract.

2104 HEARINGS REQUEST DUE TO ADVERSE ACTIONS

An adverse action refers to denials, terminations, reductions or suspensions of a recipient's eligibility determination or an applicant's request for services. The DHCFP must grant an opportunity for a hearing to an applicant/recipient/designated representative/LRI in the event an adverse action is taken by the DHCFP.

2104.1 SUSPENDED WAIVER SERVICES

A. A recipient's case must be suspended, instead of closed, if it is likely the recipient will be eligible again for waiver services within the next 60 days (for example if a recipient is admitted to an institutional setting, such as a hospital, a NF, or ICF/IID).

B. After receiving written notification from the Service Coordinator with the admission date and the request for suspension of waiver services, a NOD identifying the effective date and the reason for suspension will be provided to the recipient by the DHCFP LTSS unit.

C. If at the end of 60 days the recipient has not been removed from suspension status, the waiver must be terminated.

D. The DHCFP LTSS unit sends a NOD to the recipient and/or designated representative/LRI advising them of the date and reason for the waiver closure/termination.

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

2104.2 RELEASE FROM SUSPENDED WAIVER SERVICES

When a recipient has been released from the hospital, NF or an ICF/IID before 60 days from the admit date, the Service Coordinator must do the following within five working days:

A. Notify the DHCFP LTSS Unit of the release of suspension.

B. Complete a new PCP if there has been a significant change in the recipient's condition needs. If a change in services is expected to resolve in less than 30 days, a new PCP is not necessary. Documentation of the temporary change must be made in the Service Coordinator's notes. The date of the resolution must also be documented in the Service Coordinator's notes.

C. Complete a new Service Authorization, if necessary.

D. Contact the service providers(s) to re-establish services.

2104.3 DENIAL OF WAIVER APPLICATION

Reasons an applicant will be denied for waiver services:

a. The applicant does not meet the criteria of being diagnosed with intellectual or developmental disability.

b. The applicant does not meet the LOC criteria for placement in an ICF/IID).

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

d. The applicant fails to cooperate with the Service Coordinator or the HCBS providers in establishing and/or implementing the PCP implementing waiver services or verifying eligibility for waiver services.

e. The applicant's support system is not adequate to provide a safe environment during the time when HCBS are not being provided. HCBS services are not a substitute for natural and informal supports provided by family, friends or other available community resources.

f. The applicant fails to show a need for HCBS.

g. The applicant would not require imminent placement in an ICF/IID if HCBS were not available. (Imminent placement means within 30 to 60 days.)

h. Another agency or program will provide the services.

i. The ADSD has filled the number of slots allocated to the ID Waiver. The applicant has been approved for the waiver waitlist and will be contacted when a slot is available.

When the application for waiver services is denied the DHCFP LTSS Unit will issue a NOD, within five business days, to the recipient or designated representative/LRI identifying the reason for denial. The Date of Action (DOA) is the same date as the NOD date.

2104.4 TERMINATION OF WAIVER SERVICES

Reasons to terminate a recipient from the waiver:

A. The recipient no longer meets the criteria of an intellectual or developmental disability.

B. The recipient no longer meets the LOC criteria for placement in an ICF/IID.

C. The recipient has requested termination of waiver services.

D. The recipient has failed to cooperate with the Service Coordinator or HCBS providers in establishing and/or implementing the support plan, implementing waiver services, or verifying eligibility for waiver services.

E. The recipient's support system is not adequate to provide a safe environment during the time when HCBS are not being provided. HCBS Waiver services are not a substitute for natural and informal supports provided by family, friends or other available community resources.

F. The recipient fails to show a continued need for HCBS.

G. The recipient no longer requires imminent ICF/IID placement if HCBS Waiver services were not available. (Imminent placement means within 30 to 60 days.)

H. The recipient has moved out of state.

I. Another agency or program will provide the services.

J. The recipient has been, or is expected to be, institutionalized over 60 days (in a hospital, nursing facility, ICF/IID, or incarcerated) ****See below.

K. The ADSD has lost contact with the recipient.

L. Death of the recipient.

When a recipient is scheduled to be terminated from the ID Waiver, the Service Coordinator will send a notification to the DHCFP LTSS Unit identifying the reason for termination. The DHCFP LTSS Unit will send a NOD to the recipient or the recipient's designated representative/LRI. The form must be mailed by the DHCFP to the recipient at least 13 calendar days before the DOA on the NOD. Refer to MSM Chapter 3100 for exceptions to the advance notice.

****Service Coordinators must track recipient stays in an institutional setting. Five days prior to the 45th day, the Service Coordinator will send a notification to the DHCFP LTSS Unit identifying the 60th day of inpatient status, which is the termination date for waiver services.

Waiver slots must be held for 90 days, from the date the NOD is sent to the recipient indicating termination or institutional placement, in case they are released and need waiver services upon release.

2104.5 REDUCTION OR DENIAL OF WAIVER SERVICES

Reasons to reduce or deny waiver services:

a. The recipient no longer needs the number of service/support hours/days which were previously provided.

b. The recipient no longer needs the service/supports previously provided.

c. The recipient's parent and/or designated representative/LRI is responsible for the maintenance, health care, education and support of their minor child or ward.

d. The recipient's support system is providing the service.

e. The recipient has failed to cooperate with the Service Coordinator or HCBS providers in establishing and/or implementing the support plan, implementing waiver services, or verifying eligibility for waiver services.

f. The recipient has requested the reduction of supports/services.

g. The recipient's ability to perform tasks has improved.

h. Another agency or program will provide the service.

i. Another service will be substituted for the existing service.

j. The recipient has reached the authorized unit or annual service limit.

When a recipient has a reduction of waiver services, the Service Coordinator will send a notification to the DHCFP LTSS Unit identifying the reason for the reduction and what the service is being reduced to. The LTSS Unit will send a NOD to the recipient or the recipient's designated representative/LRI. The form must be mailed by the DHCFP to the recipient at least 13 calendar days before the DOA on the NOD.

When a recipient is denied waiver services, the Service Coordinator will send a notification to the DHCFP LTSS Unit identifying the reason for the denial. The LTSS Unit will send a NOD to the recipient or the recipient's designated representative/LRI within five days, identifying the reason for denial. The DOA is the same date of the NOD date.

2104.6 REAUTHORIZATION WITHIN 90 DAYS

When a recipient is placed in an institutional setting such as nursing facility, ICF/IID, or hospital, they must be sent a NOD terminating them from the waiver 60 days from admit date. Their waiver slot must be held for 90 days from the NOD date. A recipient may be placed back in that slot if they are released within 90 days of the NOD date, and request reinstatement, but must continue to meet waiver eligibility criteria. After 90 days, their slot may be given to the next individual on the

wait list. If a recipient requests reinstatement after the 90 days expired, they are treated as a new referral.

The Service Coordinator will send a notification to the DHCFP LTSS Unit identifying the reinstatement date.

2104.7 HEARINGS PROCEDURES

Please reference MSM Chapter 3100, Hearings, for hearings procedures.