

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER



September 24, 2019

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: TAMMY MOFFITT, CHIEF OF OPERATIONS

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 2200 – HOME AND COMMUNITY BASED WAIVER
(HCBW) FOR THE FRAIL ELDERLY

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 2200 – Home and Community Based Waiver (HCBW) for the Frail Elderly are being proposed to include mandate as per the 21st Century Cures Act.

In December 2016, Congress passed H.R. 34 – 21st Century Cures Act, mandating that all states require the use of an Electronic Visit Verification (EVV) System for all Medicaid funded personal care services that are provided under a state plan or a waiver of the plan, including services provided under Section 1915(c).

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: Entities Financially Affected: This proposed change affects all Medicaid-enrolled providers delivering specific waiver services. Those provider types include but are not limited to: Waiver for the Frail Elderly (PT 48).

Financial Impact on Local Government: Unknown at the time.

These changes are effective September 25, 2019.

<u>Material Transmitted</u>	<u>MATERIAL SUPERSEDED</u>
MTL 18/19	MTL 38/11, 31/10
MSM Ch 2200 – Home and Community Based Waiver (HCBW) for the Frail Elderly	MSM Ch 2200 – Home and Community Based Waiver (HCBW) for the Frail Elderly

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2201	Authority	Added new authorities as per the new policy mandate.
2203.2B(2)	Provider Responsibilities	Added information regarding Electronic Visit Verification policy.
2203.5B	Provider Responsibilities	Added provider responsibility related to EVV policy and further clarification regarding requirement, expectations and documentation.
2203.5C	Recipients Responsibilities	Created new section for recipient's responsibilities under Homemaker Service and added two new recipient responsibilities related to EVV policy.
2203.6B	Provider Responsibilities	Added provider responsibility related to EVV policy and further clarification regarding requirement, expectations and documentation.
2203.6C	Recipients Responsibilities	Created new section for recipient's responsibilities under Chore Service and added two new recipient responsibilities related to EVV policy.
2203.7B	Provider Responsibilities	Added provider responsibility related to EVV policy and further clarification regarding requirement, expectations and documentation.
2203.7C	Recipients Responsibilities	Created new section for recipient's responsibilities under Respite Service and added two new recipient responsibilities related to EVV policy.
2203.10B	Provider Responsibilities	Added provider responsibility related to EVV policy and further clarification regarding requirement, expectations and documentation.
2203.10C	Recipients Responsibilities	Created new section for recipient's responsibilities under Adult Companion Service and added two new recipient responsibilities related to EVV policy.

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2200 INTRODUCTION

The Home and Community-Based Waiver (HCBW) Program recognizes that many individuals at risk of being placed in hospitals or nursing facilities can be cared for in their homes and communities, preserving their independence and ties to family and friends at an average cost no higher than that of institutional care.

The Division of Health Care Financing and Policy's (DHCFP) Waiver for the Frail Elderly originated in 1987. The provision of waiver services is based on the identified needs of the waiver recipient. Every biennium the service needs and the funded slot needs of the waiver program are reviewed by the Aging and Disability Services Division (ADSD) and by the DHCFP (also known as Nevada Medicaid) and presented to the Nevada State Legislature for approval. Nevada is committed to the goal of providing the elderly with the opportunity to remain in a community setting in lieu of institutionalization. Nevada understands that people who are elderly are able to lead satisfying and productive lives when they are provided the needed services and supports to do so. The Division is committed to the goals of self-sufficiency and independence.

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2201 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 home and community-based services to eligible individuals who may require such services in order to remain in their communities and avoid institutionalization. The DHCFP Home and Community-Based Waiver (HCBW) for the Frail Elderly is an optional service program approved by the Centers for Medicare and Medicaid Services (CMS). This waiver is designed to provide eligible Medicaid waiver recipients access to both 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, when appropriate.

The DHCFP has the flexibility to design this waiver and select the mix of waiver services that best meet the goals of the program. This flexibility is predicated on administrative and legislative support, as well as federal approval.

Statutes and Regulations:

- Social Security Act: 1915(c) (HCBW)
- Social Security Act: 1916(e) (Cost Sharing – Patient Liability)
- Social Security Act: 1902(w) (State Plan for Medical Assistance)
- Omnibus Budget Reconciliation Act of 1987
- Balanced Budget Act of 1997
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- 42 CFR Part 441, Subparts G and H (Home and Community-Based Services (HCBS): Waiver Requirements; HCBS Waivers for Individuals Age 65 or Older: Waiver Requirements)
- 42 CFR Part 418 (Hospice Care)
- 42 CFR Part 431, Subparts B and E (General Administrative Requirements; Fair Hearing for Applicants and Recipients)
- 42 CFR Part 440 (Services: General Provisions)
- 42 CFR Part 489, Subpart I (Advanced Directives)

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- State Medicaid Manual, Section 4440 (HCBW, Basis, Scope and Purpose)
- Nevada’s Home and Community Based Waiver for the Frail Elderly Control Number
- Nevada Revised Statutes (NRS) Chapters 200 (Crimes Against the Person), 426 (Persons with Disabilities), 427A (Services to Aging Persons and Persons with Disabilities), 422 (Health Care Financing and Policy), 449 (Medical and Other Related Facilities), 616 (Industrial Insurance), 629 (Healing and Arts Generally)
- Nevada Administrative Code (NAC) Chapters 427A (Services to Aging Persons), 441A (Communicable Diseases), 449 (Medical and Other Related Facilities)
- **21st Century Cures Act, H.R. 34, Sec. 12006 – 114th Congress**
- **H.R. 6042 – 115th Congress**

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2203 POLICY

2203.1 ADMINISTRATIVE CASE MANAGEMENT ACTIVITIES

Administrative case management activities are performed by Aging and Disability Services Division (ADSD) case managers and refer to data collection for eligibility verification, Level of Care (LOC) evaluation, Plan of Care (POC) development, and other case management activities that are not identified on the POC.

2203.1A COVERAGE AND LIMITATIONS

Administrative case management activities include:

1. Intake referral;
2. Facilitating Medicaid eligibility, which may include assistance with the Medical Assistance to the Aged, Blind and Disabled (MAABD) application and obtaining documents required for eligibility determination;
3. Preliminary and ongoing assessments, evaluations and completion of forms required for service eligibility:
 - a. The POC identifies the waiver services as well as other ongoing community support services that the recipient needs in order to live successfully in the community. The POC must reflect the recipient's service needs and include both waiver and non-waiver services in place at the time of POC completion, along with informal supports that are necessary to address those needs.
 - b. The recipient's level of care, functional status and needs addressed by the POC must be reassessed annually or more often as needed. The recipient must also be reassessed when there is a significant change in his/her condition which influences eligibility. The reassessment is to be conducted during a face-to-face visit.
 - c. If services documented on a POC are approved by the recipient and the case manager and the recipient signature cannot be obtained due to extenuating circumstances, services can commence with verbal approval from the recipient. Case managers must document the recipient's verbal approval in the case notes and obtain the recipient signature on the POC as soon as possible.
4. Issuance of Notices of Actions (NOA) to the Division of Health Care Financing and Policy (DHCFP) Central Office Waiver Unit staff to issue a Notice of Decision (NOD) when a waiver application is denied;

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5. Coordination of care and services to collaborate in discharge planning to transition applicants from facilities;
6. Documentation for case files prior to applicant's eligibility;
7. Case closure activities upon termination of service eligibility;
8. Outreach activities to educate recipients or potential recipients on how to enter into care through a Medicaid Program;
9. Communication of the POC to all affected providers;
10. Ensure completion of prior authorization form, if required, for all waiver services documented on the POC for submission into the Medicaid Management Information System (MMIS).

2203.1B PROVIDER RESPONSIBILITIES

1. Administrative case management providers (social workers, nurses, certified case managers, etc.) must be currently licensed as a Social Worker by the State of Nevada Board of Examiners for Social Workers or as a Registered Nurse by the Nevada State Board of Nursing.
2. Must have a valid driver's license and the ability to conduct home visits.
3. Must adhere to Health Insurance Portability and Accountability Act (HIPAA) requirements.
4. Must have a Federal Bureau of Investigation (FBI) criminal history background check.

2203.1C RECIPIENT RESPONSIBILITIES

1. Applicant/recipients and/or their authorized representative must cooperate with the ADSD by assisting with the assessment and reassessment process, accurately representing skill level needs, wants, resources and goals.
2. Applicants/recipients together with the case manager must develop and/or review the POC.

2203.2 WAIVER ELIGIBILITY CRITERIA

The DHCFP's Home and Community-Based Waiver (HCBW) for the Frail Elderly waives certain statutory requirements and offers waiver services to eligible recipients to assist them to remain in their own homes or community.

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2203.2A COVERAGE AND LIMITATIONS

1. Services are offered to eligible recipients who, without the waiver services, would require institutional care (provided in a hospital or nursing facility) within 30 days or less. Recipients on this waiver must meet and maintain Medicaid's eligibility requirements for the waiver.
2. The HCBW for the Frail Elderly is limited by legislative mandate to a specific number of recipients who can be served through the waiver per year (slots). When all waiver slots are full, the ADSD utilizes a wait list to prioritize applicants who have been presumed to be eligible for the waiver.
3. When funding becomes available, the applicant will be processed for the program based on LOC score, risk factors, and date of referral. Applicants will be considered for a higher advancement on the Wait List based on whether they meet additional criteria. The following criteria may be utilized:
 - a. Applicants currently in an acute care or nursing facility and desiring discharge;
 - b. Applicants with the highest LOC score indicating greatest functional deficits;
 - c. Applicants requiring services due to a crisis or emergency such as a significant change in support system;
 - d. Applicants transitioning from another waiver;
 - e. Applicants with a terminal illness; or
 - f. Applicants requiring at least minimal essential personal care assistance (bathing, toileting and eating) as defined by NRS 426.723.
4. Waiver services may not be provided while a recipient is an inpatient of an institution.
5. HCBW for the Frail Elderly Eligibility Criteria:
 - a. Eligibility for Medicaid's HCBW for the Frail Elderly is determined by the DHCFP, ADSD and the Division of Welfare and Supportive Services (DWSS). These three State agencies collaboratively determine eligibility for the Frail Elderly Waiver as follows:
 1. Waiver benefit plan eligibility is determined by ADSD and authorized by the DHCFP Central Office Waiver Unit by confirming the following criteria:

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- a. Applicants must be 65 years of age or older;
- b. Each applicant/recipient must meet and maintain a level of care for admission into a nursing facility and would require imminent placement in a nursing facility (within 30 days or less) if HCBW services or other supports were not available;
- c. Each applicant/recipient must demonstrate a continued need for the services offered under the HCBW for the Frail Elderly to prevent placement in a nursing facility or hospital. Utilization of State Plan Services only does not support the qualifications to be covered by the waiver;
- d. The applicant/recipient must require the provision of one waiver service at least monthly;
- e. The applicant/recipient must have an adequate support system. This support system must be in place to ensure the physical, environmental and basic care needs of the applicant/recipient are met in order to provide a safe environment during the hours when home and community-based services are not being provided; and
- f. Applicants may be placed from a nursing facility, an acute care facility, another HCBW program, or the community.
- g. Residential facility for groups:

In addition to the requirements listed above:

1. Applicant/recipient must meet the criteria for placement in a Category 1 or 2 Residential Facility for Groups or have the appropriate endorsement for the admission from Health Care Quality and Compliance (HCQC).
2. Waiver applications must be approved by the DHCFP Central Office Waiver Unit to ensure the level of care criteria is met.
3. DWSS validates the applicant is eligible for Medicaid waiver services using institutional income and resource guidelines.
 - a. Recipients of the HCBW for the Frail Elderly must be Medicaid eligible for full Medicaid benefits for each month in which waiver services are provided.

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- b. Services for the HCBW for the Frail Elderly shall not be provided and will not be reimbursed until the applicant is found eligible for benefit plan services, full Medicaid eligibility, and prior authorization as required.
 - c. Medicaid recipients in the HCBW for the Frail Elderly may have to pay for part of the cost of the waiver services. The amount they are required to pay is called patient liability.
4. If an applicant is determined eligible for more than one HCBW program, the individual cannot receive services under two or more such programs at the same time. The applicant must choose one HCBW program and receive services provided by that program.
 5. Recipients of the HCBW for the Frail Elderly who are enrolled or elect to enroll in a hospice program may be eligible to remain on the waiver if they require waiver services to remain in the community. Close coordination between the hospice agency and the waiver case manager is required to prevent any duplication of services. Refer to Medicaid Services Manual (MSM) Chapter 3200 for additional information on hospice services.

2203.2B PROVIDER RESPONSIBILITIES

1. Providers are responsible for confirming the recipient’s Medicaid eligibility each month prior to rendering waiver services.
2. **ELECTRONIC VISIT VERIFICATION (EVV):**

The 21st Century Cures Act requires the use of an of an EVV system to document services that are provided for all personal care services under a Medicaid state plan or waiver program. This mandate requires provider agencies to use an EVV system to record service delivery visit information. Nevada Medicaid utilizes the open-system model, procuring a vendor but also allows agencies to utilize their own if it meets the 21st Century Cures Act requirements for documentation.

All service information must be recorded in an electronic system that interfaces with either a telephone or an electronic device that generates a timestamp. The provider agency must verify the EVV record, including any visit maintenance, prior to submitting a claim associated with the EVV record. All claims must be supported by an EVV entry into an EVV system prior to claim submission.

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

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a. STATE OPTION:

1. The EVV system electronically captures:

- a. The type of service performed, based on procedure code;
- b. The individual receiving the service;
- c. The date of the service;
- d. The location where service is provided;
- e. The individual providing the service;
- f. The time the service begins and ends.

2. The EVV system must utilize one or more of the following:

- a. The agency/personal care attendant's smartphone;
- b. The agency/personal care attendant's tablet;
- c. The recipient's landline telephone;
- d. The recipient's cellular phone (for Interactive Voice Response (IVR) purposes only);
- e. Other GPS-based device as approved by the DHCFP.

b. DATA AGGREGATOR OPTION:

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

- a. Appropriate form must be approved by the DHCFP before use of system to ensure all data requirements are being collected to meet the 21st Century Cures Act.
- b. At a minimum, data uploads must be completed monthly into data aggregator.

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2203.2C RECIPIENT RESPONSIBILITIES

Applicants/recipients must meet and maintain all eligibility criteria to become eligible and to remain on the HCBW for the Frail Elderly.

2203.2D MEDICAID EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)

Recipients of this waiver are not eligible for EPSDT.

2203.3 WAIVER SERVICES

The DHCFP determines which services will be offered under the HCBW for the Frail Elderly. Providers and recipients must agree to comply with all program requirements for service provision.

2203.3A COVERAGE AND LIMITATIONS

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

1. Direct Service Case Management.
2. Homemaker Services.
3. Chore Services.
4. Respite Care Services.
5. Personal Emergency Response System (PERS).
6. Adult Day Care Services.
7. Adult Companion Services.
8. Augmented Personal Care (provided in a residential facility for groups).

2203.3B PROVIDER RESPONSIBILITIES

1. All Service Providers:
 - a. Must obtain and maintain a HCBW for the Frail Elderly provider number (Provider Type 48 or 57 as appropriate) through the DHCFP's QIO-like vendor.

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- b. In addition to this Chapter, the provider must also comply with rules and regulations for providers as set forth in the MSM Chapter 100.
- c. Must understand the authorized service specification on the POC, record keeping responsibilities and billing procedures for provided waiver services.
- d. Must understand that payment for services will be based on the level of service or specific tasks identified on the POC and will not be made to legally responsible individuals for furnishing waiver services.
- e. All providers may only provide services that have been identified in the POC and that, if required, have a prior authorization.
- f. Providers must verify the Medicaid eligibility status of each HCBW for Frail Elderly recipient each month.
- g. Criminal Background Checks

All agency personnel, including owners, officers, administrators, managers, employees and consultants must undergo State and FBI background checks upon licensure and then at a minimum of every five years thereafter to ensure no convictions of applicable offenses have been incurred (ADSD personnel must follow State of Nevada policy regarding required background checks) and the safety of recipients is not compromised.

1. The DHCFP policy requires all waiver providers have State and Federal criminal history background checks completed. The DHCFP fiscal agent will not enroll any provider agency whose owner or operator has been convicted of a felony under State or Federal law for any offense which the DHCFP determines is inconsistent with the best interest of recipients. Additional information may be found in MSM Chapter 100, Section 102.2.
2. Criminal background checks must be conducted through the Nevada Department of Public Safety (DPS). Agencies do not have to have a DPS account. Individuals may request their own personal criminal history directly from DPS and the FBI and must have the results sent directly to the employer. Information and instructions may be found on the DPS website at:
<http://nvrepository.state.nv.us/criminal/forms/PersonalNevadaCriminalHistory.pdf>.
3. The employer is responsible for reviewing the results of the employee criminal background checks and maintaining the results within the

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employee's personnel records. Continued employment is at the sole discretion of the servicing agency. However, the DHCFP has determined certain felonies and misdemeanors to be inconsistent with the best interests of recipients. The employer should gather information regarding the circumstances surrounding the conviction when considering ongoing employment and have this documented in the employee's personnel file. These convictions include (not all inclusive):

- a. murder, voluntary manslaughter or mayhem;
- b. assault with intent to kill or to commit sexual assault or mayhem;
- c. sexual assault, statutory sexual seduction, incest, lewdness, indecent exposure or any other sexual related crime;
- d. abuse or neglect of a child or contributory delinquency;
- e. a violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in Chapter 454 of the NRS;
- f. a violation of any provision of NRS 200.700 through 200.760;
- g. criminal neglect of a patient as defined in NRS 200.495;
- h. any offense involving fraud, theft, embezzlement, burglary, robbery, fraudulent conversion or misappropriation of property;
- i. any felony involving the use of a firearm or other deadly weapon;
- j. abuse, neglect, exploitation or isolation of older persons;
- k. kidnapping, false imprisonment or involuntary servitude;
- l. any offense involving assault or battery, domestic or otherwise;
- m. conduct inimical to the public health, morals, welfare and safety of the people of the State of Nevada in the maintenance and operation of the premises for which a provider contract is issued;
- n. conduct or practice that is detrimental to the health or safety of the occupants or employees of the facility or agency; or

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

Providers are required to initiate diligent and effective follow up for results of background checks within 90 days of submission of prints and continue until results are received. This is particularly important when an “undecided” result is received. If an employee believes that the information provided as a result of the criminal background check is incorrect, the individual must immediately inform the employing agency in writing. Information regarding challenging a disqualification is found on the DPS website at: <http://dps.nv.gov> under Records and Technology.

Providers must be able to: perform the duties of the job; demonstrate maturity of attitude toward work assignments; communicate effectively; work under intermittent supervision; deal with minor emergencies arising in connection with the assignment and act accordingly, reporting these to the proper supervisor; demonstrate ability to understand, respect and maintain confidentiality in regards to the details of case circumstances.

- h. Each provider must have a file for each recipient. In the recipient’s file, the provider must have a copy of the current POC and maintain daily records, fully documenting the scope and frequency of services as specified on the POC. The documentation will include the recipient’s initials daily with a full signature of the recipient on each record. If the recipient is unable to provide a signature due to cognitive and/or physical limitations, this will be clearly documented on the POC. The provider will initial after the daily services are delivered, with a full signature of the provider on each daily record. Providers may use electronic signatures on the daily record documentation but using an electronic signature does not remove the provider’s responsibility for providing accurate and verifiable documentation indicating the scope and frequency of services provided. If a provider elects to use electronic signatures, they must have weekly printouts of the daily record in the recipient’s file or make available upon request.

Periodically, Medicaid Central Office/ADSD staff may request this documentation to compare it to submitted claims. These records must be maintained by the provider for at least six years after the date the claim is paid.

- i. Must have a separate file for each employee. Records of all the employee’s training, required health certificates, first aid and cardiopulmonary resuscitation certifications and documents which are evidence that the employee has been tested for tuberculosis must be in the file. Please refer to NAC 449.200 for additional requirements.

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- j. The number of hours specified on each recipient's POC, for each specific service listed (except Case Management), will be considered the maximum number of hours allowed to be provided by the caregiver and paid by the DHCFP's QIO-like vendor, unless the case manager has approved additional hours due to a temporary condition or circumstance.
- k. Services for waiver recipients residing in a residential facility for groups should be provided as specified on the POC and at the appropriate authorized service level.
- l. If fewer services are provided than what is authorized on the POC, the reason must be adequately documented in the daily record and communicated to the case manager.
- m. Cooperate with ADSD and/or State or Federal reviews or inspections.
- n. Serious Occurrence Report (SOR):

Providers must report any recipient incidents, or issues regarding the provider/employee's ability to deliver services to the ADSD case manager by telephone/fax within 24 hours of discovery. A completed SOR form report must be made within five working days and maintained in the agency's recipient record.

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

1. Suspected physical or verbal abuse;
2. Unplanned hospitalization;
3. Neglect, exploitation or isolation of the recipient;
4. Theft;
5. Sexual harassment or sexual abuse;
6. Injuries requiring medical intervention;
7. An unsafe working environment;
8. Any event which is reported to Elder Protective Services or law enforcement agencies;
9. Death of the recipient during the provision of waiver services; or

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10. Loss of contact with the recipient for three consecutive scheduled days.
11. Medication errors resulting in injury, hospitalization, medical treatment or death.

The State of Nevada has established mandatory reporting requirements of suspected incidents of Elder Abuse, Neglect, Isolation and Exploitation. ADSD and local law enforcement are the receivers of such reports. Suspected elder abuse must be reported as soon as possible, but no later than 24 hours of identification/suspicion. Refer to NRS 200.5091 to 200.50995 regarding elder abuse or neglect.

- o. Adhere to HIPAA requirements.

Refer to MSM Chapter 100 for information on HIPAA, privacy and confidentiality of recipient records and other protected health information.
- p. Obtain and maintain a business license as required by city, county or state government, if applicable.
- q. Providers for residential facility for groups must obtain and maintain required HCQC licensure.

2. Aging and Disability Services Division (ADSD):

In addition to the provider responsibilities listed in Section 2203.3B, ADSD must:

- a. maintain compliance with the Interlocal Agreement with the DHCFP to operate the HCBW for the Frail Elderly.
- b. comply with all waiver requirements as specified in the HCBW for the Frail Elderly.

3. Qualification and Training:

- a. All service providers must arrange training for employees who have direct contact with recipients of the HCBW programs and must have service specific training prior to performing a waiver service. Training at a minimum must include, but not limited to:
 1. policies, procedures and expectations of the agency relevant to the provider, including recipient's and provider's rights and responsibilities;
 2. procedures for billing and payment;

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3. record keeping and reporting including daily records and SORs;
4. information about the specific needs and goals of the recipients to be served; and
5. interpersonal and communication skills and appropriate attitudes for working effectively with recipients including: understanding care goals; respecting recipient rights and needs; respect for age, cultural and ethnic differences; recognizing family relationships; confidentiality; respecting personal property; ethics in dealing with the recipient, family and other providers; handling conflict and complaints; and other topics as relevant.

b. Residential facility for groups:

In addition to the requirements listed above:

1. Caregivers of a residential facility for groups must be at least 18 years of age; be responsible and mature and have the personal qualities which will enable him or her to understand the problems of the aged and disabled; demonstrate the ability to read, write, speak and understand the English language; must possess the appropriate knowledge, skills and abilities to meet the needs of the residents of the facility and annually receive no less than eight hours of training related to providing for the needs of the residents of a residential facility for groups; must be knowledgeable in the use of any prosthetic devices or dental, vision or hearing aids that the residents use and must understand the provisions of NAC 449.156 to NAC 449.27706, inclusive, and Sections 2 and 3 of the regulation, and sign a statement that he/she has read those provisions.
2. If a caregiver assists a resident of a residential facility for groups in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver must: before assisting a resident in the administration of a medication, receive the training required pursuant to paragraph (e) of Subsection 6 of NRS 449.037, which must include, at least 16 hours of training in the management of medication consisting of not less than 12 hours of classroom training and not less than four hours of practical training, and obtain a certificate acknowledging the completion of such training; receive annually at least eight hours of training in the management of medication and provide the residential facility for groups with satisfactory evidence of the content of the training and his or her attendance at the training; complete the training program developed by the administrator of the residential facility for groups pursuant to paragraph (e) of Subsection 1 of NAC 449.2742; and annually

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pass an examination related to the management of medication approved by the HCQC.

3. Within 30 days after a caregiver is employed at the facility, he/she must be trained in First Aid and Cardiopulmonary Resuscitation (CPR) as described in NAC 449.231 and be able to recognize and appropriately respond to medical and safety emergencies.
4. Caregivers must have training specific to the waiver population being cared for at the residential facility for groups, including the skills needed to care for recipients with increasing functional, cognitive and behavioral needs.
5. Service providers/employees must complete either a QuantiFERON®-TB Gold blood test (QFT-G) or a two step (TB) Tuberculin skin test prior to initiation of services for a Medicaid recipient. Thereafter, each service provider/employee must receive a QFT-G blood test or one step TB skin test annually, prior to the expiration of the initial test. If the service provider/employee has a documented history of a positive QFT-G or TB skin test (+10 mm induration or larger), the service provider/employee must have clearance by a chest X-ray prior to initiation of services for a Medicaid recipient.

If the service provider/employee has been medically cleared after a documented history of a positive QFT-G or TB skin test which was 10 mm or larger and then by chest X-ray, the service provider/employee must have documentation annually which demonstrates no signs or symptoms of active tuberculosis. The annual screening for signs and symptoms must address each of the following areas of concern and must be administered by a qualified health care provider as defined in NAC 441A.110.

- a. Has had a cough for more than three weeks;
- b. Has a cough which is productive;
- c. Has blood in his sputum;
- d. Has a fever which is not associated with a cold, flu or other apparent illness;
- e. Is experiencing unexplained weight loss; or
- f. Has been in close contact with a person who has active tuberculosis.

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Annual screening for signs and symptoms of active disease must be completed prior to the one-year anniversary of the last screening. Documentation of the annual screening and the results must be maintained in the service provider/employee file.

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

In addition, providers must also comply with the tuberculosis requirements outlined in NAC 441A.375 and NAC 441A.380.

c. Exemptions from Training for Provider Agencies:

1. The provider agency 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.
2. The exemption and its rationale must be provided in writing and a copy of the exemption must be placed in the employee's file.
3. ADSD/DHCFP may review exemptions for appropriateness.

2203.3C RECIPIENT RESPONSIBILITIES

The recipient or, if applicable, the recipient's authorized representative will:

1. notify the provider(s) and the ADSD case manager of any change in Medicaid eligibility;
2. notify the provider(s) and the ADSD case manager of current insurance information, including the name of the insurance coverage, such as Medicare;
3. notify the provider(s) and the ADSD case manager of changes in medical status, support systems, service needs, address or location changes, and/or any change in status of authorized or legal representative;
4. treat all providers and their staff members appropriately;

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5. initial and sign the daily record(s) to verify that services were provided. If the recipient is unable to provide a signature due to cognitive and/or physical limitations, this will be clearly documented on the POC;
6. notify the provider or the ADSD case manager when scheduled visits cannot be kept or services are no longer required;
7. notify the provider agency or ADSD of any missed appointments by the provider agency staff;
8. notify the provider agency or the ADSD case manager of any unusual occurrences, complaints regarding delivery of services, specific staff or to request a change in caregiver or provider agency;
9. furnish the provider agency with a copy of his or her Advance Directive;
10. not request any provider to work more than the hours authorized in the POC;
11. not request a provider to work or clean for a non-recipient, family or household members;
12. not request a provider to perform services not included in the POC;
13. contact the case manager to request a change of provider agency;
14. complete, sign and submit all required forms on a timely basis; and
15. be physically available for authorized waiver services, quarterly home visits, and assessments.

2203.4 DIRECT SERVICE CASE MANAGEMENT

Direct service case management is provided to eligible recipients in the HCBW program when case management is identified as a service on the POC. The recipient has a choice of direct service case management provided by ADSD or provider agencies.

2203.4A COVERAGE AND LIMITATIONS

These services include:

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

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2. Coordination of multiple services and/or providers when applicable;
3. Monitoring the overall provision of waiver services, in an effort to protect the safety and health of the recipient and to determine that the POC goals are being met;
4. Monitoring and documenting the quality of care through monthly contact:
 - a. The case manager must have a monthly contact with each waiver recipient and/or the recipient's authorized representative; this may be a telephone contact. At a minimum, there must be a face-to-face visit with each recipient once every three months. More contacts may be made if the recipient has indicated a significant change in his or her health care status or is concerned about his or her health and/or safety.
 - b. When recipient service needs increase, due to a temporary condition or circumstance, the case manager must thoroughly document the increased service needs in their case notes. The POC does not need to be revised for temporary conditions or circumstances. A temporary condition or circumstance is defined as an increase or decrease in service needs for a period not to exceed thirty (30) days. If the recipient is utilizing a private case management agency, this information must be communicated to ADSD for prior authorization adjustment.
 - c. During the monthly contact, the case manager monitors and documents the quality of care of the recipient. Quality of care includes the identification, remediation and follow-up of health and safety issues, needs and concerns of the recipient, waiver service satisfaction and whether the services are promoting goals stated in the POC. The case manager also assesses the need for any change in services or providers. If the recipient is utilizing a private case management agency, this information must be communicated to ADSD for prior authorization adjustment.
 - d. During scheduled visits to a residential facility for groups, the case manager is responsible for reviewing the POC and daily logs as applicable for feedback from the recipient to help ensure services are delivered as authorized in the POC. In addition, the case manager is responsible for reviewing the medication log to ensure appropriate administration and documentation is completed timely.
5. Making certain that the recipient retains freedom of choice in the provision of services;
6. Notifying all affected providers of changes in the recipient's medical status, services needs, address, and location, or of changes of the status of legally responsible individuals or authorized representative;

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7. Notifying all affected providers of any unusual occurrence or change in status of a waiver recipient;
8. Notifying all affected providers of any recipient complaints regarding delivery of service or specific provider staff;
9. Notifying all affected providers if a recipient requests a change in the provider staff or provider agency; and
10. Case Managers must provide recipients with appropriate amount of case management services necessary to ensure the recipient is safe and receives sufficient services. Case management will be considered an “as needed” service. Case managers must continue to have monthly contact with recipients and/or the recipients authorized representative of at least 15 minutes, per recipient, per month. The amount of case management services billed to the DHCFP must be adequately documented and substantiated by the case manager’s notes.
11. Monitoring to assure providers of residential facility for groups meet required program standards.
12. Arranging for the relocation of the recipient, if necessary, when an alternative placement is requested or needed.

2203.4B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.3B, Case Managers must:

1. be currently licensed as Social Worker by the State of Nevada Board of Examiners for Social Workers or licensure as a Registered Nurse by the Nevada State Board of Nursing.
2. have a valid driver’s license and means of transportation to enable home visits.

In addition to the requirements listed above, private case managers must:

- a. have one year experience of working with seniors in a home based environment.
- b. also provide evidence of taxpayer ID number, Workman’s Compensation Insurance, Unemployment Insurance Account, Commercial General Liability, Business Automobile Liability Coverage and Commercial Crime Insurance.
- c. be employed by a private case management provider agency.

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2203.4C RECIPIENT RESPONSIBILITIES

1. Each recipient and/or his or her authorized representative must cooperate with the implementation of services and the implementation of the POC.
2. Each recipient is to comply with the rules and regulations of the DHCFP, ADSD, DWSS and the HCBW for the Frail Elderly.

2203.5 HOMEMAKER SERVICES

2203.5A COVERAGE AND LIMITATIONS

1. Homemaker services are provided by agencies enrolled as a Medicaid provider.
2. Homemaker services are provided when the individual regularly responsible for these activities is temporarily absent or unable to manage their private residence and is necessary to avoid placement in an institution. Services must be directed to the individual recipient and related to their health and welfare.
3. The DHCFP/ADSD is not responsible for replacing goods which are or become damaged in the provision of service.
4. Homemaker services include:
 - a. meal preparation: menu planning, storing, preparing, serving of food, cutting up food, buttering bread and plating food;
 - b. laundry services: washing, drying and folding the recipient's personal laundry and linens (sheets, towels, etc.) excludes ironing. Recipient is responsible for all laundromat and/or cleaning fees;
 - c. light housekeeping: changing the recipient's bed linens, dusting, vacuuming the recipient's living area, cleaning kitchen and bathroom areas;
 - d. essential shopping to obtain: prescribed drugs, medical supplies, groceries, and other household items required specifically for the health and maintenance of the recipient; or
 - e. assisting the recipient and family members or caregivers in learning homemaker routine and skills so the recipient may carry on normal living when the homemaker is not present.

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5. Activities the homemaker shall not perform and for which Medicaid will not pay include the following:
- a. transporting the recipient in a private car;
 - b. cooking and cleaning for the recipient’s guests, other household members or for the purposes of entertaining;
 - c. repairing electrical equipment;
 - d. ironing and mending;
 - e. giving permanents, dyeing or cutting hair;
 - f. accompanying the recipient to appointments, social events or in home socialization;
 - g. washing walls and windows;
 - h. moving heavy furniture, climbing on chairs or ladders;
 - i. purchasing alcoholic beverages that were not prescribed by the recipient’s physician;
 - j. doing yard work such as weeding or mowing lawns, trimming trees, shoveling non-essential snow covered areas, and vehicle maintenance; or
 - k. care of pets except in cases where the animal is a certified service animal.

2203.5B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.3B, Homemaker Providers must:

1. arrange and receive training related to household care, including good nutrition, special diets, meal planning and preparation, shopping information, housekeeping techniques, and maintenance of a clean, safe and healthy environment; and
2. inform recipients that the DHCFP or its QIO-like vendor is not responsible for replacement of goods damaged in the provision of service.

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

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

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2203.5C RECIPIENTS RESPONSIBILITIES

1. Agree to utilize an approved EVV system for the waiver services being received from the provider agency.
2. Confirm services were provided by electronically signing or initialing, as appropriate per service plan, the EVV record that reflects the service rendered. If IVR is utilized, a vocal confirmation is required.

2203.6 CHORE SERVICES

2203.6A COVERAGE AND LIMITATIONS

1. This service includes heavy household chores in the private residence such as:
 - a. cleaning windows and walls;
 - b. shampooing carpets;
 - c. tacking down loose rugs and tiles;
 - d. moving heavy items of furniture in order to provide safe access;
 - e. packing and unpacking for the purpose of relocation;
 - f. minor home repairs; or
 - g. removing trash and debris from the yard.
2. Chore services are intermittent in nature and may be authorized as a need arises for the completion of a specific task which otherwise left undone poses a home safety issue. These services are provided only in cases where neither the recipient, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer/agency or third party payer is capable of, or responsible for, their provision and without these services the recipient would be at risk of institutionalization. This is not a skilled, professional service.
3. In the case of rental property, the responsibility of the landlord pursuant to the lease agreement, must be examined and confirmed prior to any authorization of service. The legal responsibility of the landlord to maintain and ensure safety on the rental property shall supersede any waiver program covered services.

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2203.6B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.3B, individuals performing chore services must:

1. be able to read, write and follow written or oral instructions;
2. have experience and/or training in performing heavy household activities and minor home repair; and
3. maintain the home in a clean, sanitary and safe environment if performing heavy household chores and minor home repair services.

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

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

2203.6C RECIPIENTS RESPONSIBILITIES

1. Agree to utilize an approved EVV system for the waiver services being received from the provider agency.
2. Confirm services were provided by electronically signing or initialing, as appropriate per service plan, the EVV record that reflects the service rendered. If IVR is utilized, a vocal confirmation is required.

2203.7 RESPITE CARE

2203.7A COVERAGE AND LIMITATIONS

1. Respite care is provided on a short-term basis because of the absence or need for relief of the primary caregiver.
2. Respite care may occur in the recipient’s private home.
3. Respite care is limited to 336 hours per waiver year.

2203.7B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.3B, Respite Providers must:

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1. perform general assistance with ADLs and IADLs and provide supervision to functionally impaired recipients in their private home;
2. have the ability to read and write and to follow written or oral instructions;
3. have had experience and/or training in providing for the personal care needs of people with functional impairments;
4. demonstrate the ability to perform the care tasks as prescribed;
5. be tolerant of the varied lifestyles of the people served; and
6. arrange training in personal hygiene needs and techniques for assisting with ADLs, such as bathing, grooming, skin care, transferring, ambulating, feeding, dressing and use of adaptive aids and equipment, homemaking and household care.

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

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

2203.7C RECIPIENTS RESPONSIBILITIES

1. Agree to utilize an approved EVV system for the waiver services being received from the provider agency.
2. Confirm services were provided by electronically signing or initialing, as appropriate per service plan, the EVV record that reflects the service rendered. If IVR is utilized, a vocal confirmation is required.

2203.8 PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)

2203.8A COVERAGE AND LIMITATIONS

1. PERS is an electronic device, which enables certain recipients at high risk of institutionalization to secure help in an emergency. The recipient may also wear a portable “help” button to allow for mobility. The system is connected to the recipient’s phone and programmed to signal a response center once a “help” button is activated.
2. PERS services are limited to those recipients who live alone in a private residence, or who are alone for significant parts of the day in that residence, have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

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The recipient must be physically and cognitively capable of using the device in an appropriate and proper manner.

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

2203.8B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.3B, PERS Providers must:

1. be responsible for ensuring that the response center is staffed by trained professionals at all times;
2. be responsible for any replacement or repair needs that may occur;
3. utilize devices that meet Federal Communication Commission standards, Underwriter's Laboratory, Inc. (UL) standards or equivalent standards, and be in good standing with the local Better Business Bureau; and
4. inform recipients of any liability the recipient may incur as a result of the recipient's disposal of provider property.

2203.8C RECIPIENT RESPONSIBILITIES

1. The recipient is responsible to utilize the leased PERS equipment with care and caution and to notify the PERS provider and the ADSD case manager if the equipment is no longer working.
2. The recipient must return the equipment to the provider when the recipient no longer needs or utilizes the equipment, when the recipient terminates from the waiver program or when the recipient moves from the area.
3. The recipient must not throw away the PERS equipment. This is leased equipment and belongs to the PERS provider.

2203.9 ADULT DAY CARE SERVICES

2203.9A COVERAGE AND LIMITATIONS

1. Adult day care facilities provide services in a non-institutional community-based setting on a regularly scheduled basis. The emphasis is on social interaction in a safe environment. It is provided for four or more hours per day, one or more days per week, and is provided in accordance with the goals in the recipient's POC. The POC must indicate the number of

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days per week the recipient will attend.

2. It is provided in an outpatient setting.
3. It encompasses social service needs to ensure the optimal functioning of the recipient.
4. Meals provided are furnished as part of the program but must not constitute a “full nutritional regime” (i.e., three meals per day).
5. Service utilization and billing method (per diem/unit rate) will be prior authorized as indicated on the recipient’s POC. The per diem rate is authorized when the recipient is in attendance for six or more hours per day, and the unit rate is authorized for attendance less than six hours per day. Providers must bill in accordance with the approved PA, even if the recipient occasionally attends less than six hours. If the recipient’s overall pattern changes and consistently attends less than six hours a day, a new POC and PA will be required to update the service utilization and billing method.
6. Providers must not bill for days a recipient is not in attendance, even if it is a regularly scheduled day. Providers must keep attendance records for each recipient. Claims must reflect dates and times of service as indicated on the attendance records.
7. Reference MSM Chapter 1900 for transportation policies.

2203.9B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2303.3B, Adult Day Care Providers must:

1. Meet and maintain specifications as an adult day care provider as outlined in NAC 449 “Facilities for Care of Adults During the Day.”
2. Comply with the provisions regarding tuberculosis as outlined in NAC 441A.375 and 441A.380.

2203.10 ADULT COMPANION SERVICES

2203.10A COVERAGE AND LIMITATIONS

1. Provides non-medical care, supervision and socialization to a functionally impaired recipient in his or her home or place of residence, which may provide temporary relief for the primary caregiver.

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2. Adult companions may assist the recipient with such tasks as meal preparation and clean up, light housekeeping, shopping and facilitate transportation/escort as needed. These services are provided as an adjunct to the Adult Companion Services and must be incidental to the care and supervision of the recipient.
3. The provision of Adult Companion Services does not entail hands-on medical care.
4. This service is provided in accordance with a goal in the POC and is not purely diversional in nature.
5. Transportation is not a covered service.

2203.10B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.3B, Adult Companion Providers must:

1. be able to read, write and follow written or oral instructions; and
2. have experience or training in how to interact with recipients with disabling conditions.

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

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

2203.10C RECIPIENTS RESPONSIBILITIES

1. Agree to utilize an approved EVV system for the waiver services being received from the provider agency.
2. Confirm services were provided by electronically signing or initialing, as appropriate per service plan, the EVV record that reflects the service rendered. If IVR is utilized, a vocal confirmation is required.

2203.11 AUGMENTED PERSONAL CARE

Augmented personal care provided in a licensed residential facility for groups is a 24-hour in home service that provides assistance for functionally impaired elderly recipients with basic self-care and activities of daily living that include as part of the service:

- A. Homemaker Services;

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- B. Personal Care Services;
- C. Chore Services;
- D. Companion Services;
- E. Therapeutic social and recreational programming;
- F. Medication oversight (to the extent permitted under State Law); and
- G. Services which will ensure that residents of the facility are safe, secure, and adequately supervised.

This care is over and above the mandatory service provision required by regulation for residential facility for groups.

2203.11A COVERAGE AND LIMITATIONS

1. Augmented personal care in a licensed residential facility for groups provides assistance for the functionally impaired elderly with basic self-care and ADLs such as personal care services, homemaker, chore, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming and services that ensure that the residents of the facility are safe, secure and adequately supervised.
2. This service includes 24-hour in home supervision to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence.
3. There are three service levels of Augmented Personal Care. The service level provided is based on the recipient’s functional needs to ensure his/her health, safety and welfare in the community.
 - a. Level One

Provides supervision and cueing to monitor the quality and completion of basic self-care and ADLs. Some basic self-care services may require minimum hands on assistance. This service level provides laundry services to meet the recipient’s needs. If needed this service provides in home supervision when direct care tasks are not being completed.
 - b. Level Two

Provides minimal physical assistance with completion of basic self-care and ADLs. Some basic self-care may require a moderate level of assistance. This service level

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provides laundry services to meet the recipient's needs. If needed this service provides in home supervision with regularly scheduled checks if needed.

c. Level Three

Provides moderate physical assistance with completion of basic self-care and ADLs. Some basic self-care may require a maximal level of assistance. This service level provides laundry service to meet the recipient's needs. If needed this service provides direct visual supervision or safety systems to ensure recipient safety when supervision is not direct.

4. Federal Financial Participation (FFP) is not available to subsidize the cost of room and board furnished in a residential facility for groups.
5. Nursing and skilled services (except periodic nursing evaluations) are incidental, rather than integral to the provision of group care services. Payment will not be made for 24-hour skilled care or supervision.
6. Other individuals or agencies may also furnish care directly, or under arrangement with the residential facility for groups. However, the care provided by these other entities supplements what is being provided but does not supplant it.

2203.11B AUGMENTED PERSONAL CARE PROVIDER RESPONSIBILITIES

In addition to the responsibilities listed in Section 2203.3B providers must:

1. Be licensed and maintain standards as outlined by the Health Division, HCQC under NRS/NAC 449 Residential Facility for Groups.
2. The provider for a residential facility for groups must:
 - a. Notify ADSD within three working days when the recipient states that he or she wishes to leave the facility.
 - b. Participate with ADSD in discharge planning.
 - c. Notify ADSD within one working day if the recipient's living arrangements have changed, eligibility status has changed or if there has been a change in his or her health status that could affect his or her health, safety or welfare.
 - d. Notify ADSD of any occurrences pertaining to a waiver recipient that could affect his or her health, safety or welfare.

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- e. Notify ADSD of any recipient complaints regarding delivery of service or specific staff of the residential facility of groups.
- f. Provide ADSD with at least a 30-day notice before discharging a recipient unless the recipient's condition deteriorates and warrants immediate discharge.
- g. Be responsible for any claims submitted or payment received on the recipient's behalf; such claims should be made under penalties of perjury. Any false claims, statement or documents, or concealment of material facts may be prosecuted under applicable federal or state laws.
- h. Provide care to a newly placed recipient for a minimum of 30 days unless the recipient's condition deteriorates and warrants immediate discharge.
- i. Conduct business in such a way that the recipient retains freedom of choice.
- j. Provide transportation to and from the residential facility for groups to the hospital, a nursing facility, routine medical appointment and social outings organized by the facility.
- k. Accept only those residents who meet the requirements of the licensure and certification.
- l. Provide services to waiver eligible recipients in accordance with the recipient's plan of care, the rate, program limitations, and procedures of the DHCFP.
- m. Not use or disclose any information concerning a recipient for any purpose not directly connected with the administration of the HCBW for the Frail Elderly except by written consent of the recipient, his or her authorized or legal representative or family.
- n. Have sufficient number of caregivers present at the facility to conduct activities and provide care and protective supervision for the residents at all times. The facility must comply with HCQC staffing requirements for the specific facility type (for example, an Alzheimer facility).
- o. There must be 24-hour on site staff to meet scheduled or unpredictable needs and provide supervision, safety and security, and transportation if one or more residents are present.
- p. Not use Medicaid waiver funds to pay for the recipient's room and board. The recipient's income is to be used to cover room and board costs.

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2203.11C RECIPIENT RESPONSIBILITIES

1. Recipients are to cooperate with the providers of residential facility for groups in the delivery of services.
2. Recipients are to report any problems with the delivery of services to the residential facility for group administrator and/or ADSD case manager.

2203.12 PROVIDER ENROLLMENT/TERMINATION

All providers must comply with all the DHCFP provider enrollment requirements, provider responsibilities/qualifications, and the DHCFP provider agreement limitations. Provider non-compliance with any or all of these stipulations may result in the DHCFP's decision to exercise its right to terminate the provider's contract.

2203.12A COVERAGE AND LIMITATIONS

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

2203.12B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.3B:

1. All providers must meet all federal, state and local statutes, rules and regulations relating to the services being provided.
2. ADSD must have an Interlocal Agreement with the DHCFP in order to provide services.
3. All Other Service Providers must apply for and maintain a contract with the DHCFP through its Fiscal Agent.

2203.13 INTAKE PROCEDURES

ADSD has developed policies and procedures to ensure fair and adequate access to the Home and Community-Based Waiver for the Frail Elderly.

2203.13A COVERAGE AND LIMITATIONS

1. Referral
 - a. A referral or inquiry for the waiver may be initiated by phone, mail, fax, in person or by another party on behalf of the potential applicant.

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- b. ADSD will make phone/verbal contact with the applicant/representative within seven working days of the referral date. If a potential applicant appears to be eligible, a face to face visit is scheduled to assess eligibility including a level of care screening.
- c. If the intake worker determines during the referral process that the potential applicant does not appear to meet the waiver criteria of financial eligibility, level of care, or waiver service need, the applicant will be referred to other agencies for any needed services or assistance.
- d. Even if the potential applicant does not appear eligible or if no slot is available for the HCBW for the Frail Elderly, he or she must be verbally informed of the right to continue the Medicaid application process through DWSS. If DWSS determines the applicant to be ineligible for Medicaid, the applicant may have the right to a fair hearing through the DWSS.

2. Wait List/No Waiver Slots Are Available

- a. Once ADSD has identified that the potential applicant appears eligible and there are no waiver slots available:
 1. The applicant will be placed on the waiver wait list and be considered for a higher advancement based on whether they meet additional criteria. Refer to Section 2203.2A.3.
 2. If it has been determined no slot is expected to be available within the 90 day determination period, ADSD will notify the DHCFP Central Office Waiver Unit to deny the application due to no slot available and send out a NOD stating the reason for the denial. The applicant will remain on the wait list.

3. A Waiver Slot is Available

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

- a. The procedure used for processing an applicant is as follows:
 1. The ADSD case manager will make certain that the Medicaid application, through DWSS, has been completed or updated and will assist in this process as needed.
 2. The ADSD case manager will schedule a face-to-face interview with the applicant to complete the assessment.

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3. An Authorization for Release of Information form is needed for all waiver applicants and provides written consent for ADSD to release information about the applicant to others.

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

4. The applicant will be given the right to choose waiver services in lieu of placement in a nursing facility. If the applicant and/or legal representative prefers placement in a nursing facility, the case manager will assist the applicant in arranging for facility placement.
5. The applicant will be given the right to request a hearing if not given a choice between HCBW services and nursing facility placement.
6. ADSD will forward an initial assessment (IA) packet to the DHCFP Central Office Waiver Unit which will include:
 - a. LOC screening;
 - b. Social Health Assessment;
 - c. a written POC is developed in conjunction with the applicant/authorized representative based on the assessment of the applicant's health and welfare needs;
 - d. the Statement of Understanding/Choice (SOU) must be complete with signature and dates; and
 - e. a HCBW Eligibility Status Form (Form NMO-2734) requesting the DHCFP's Central Office Waiver Unit approval with the date of approval indicated.
7. Applicants will be given free choice of all qualified Medicaid providers of each Medicaid covered service included in his/her written POC. Current POC information as it relates to the services provided must be given to all service providers.
8. The POC is subject to the approval by the DHCFP Central Office Waiver Unit staff.
9. All required forms must be complete with signature and dates where

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required.

If the DHCFP Central Office Waiver Unit approves the application, the following will occur:

- a. Form NMO-2734 is sent by the DHCFP Central Office Waiver Unit to ADSD and DWSS stating the application has been approved; and
- b. Once the DHCFP Central Office Waiver Unit and DWSS have approved the application, waiver service can be initiated;

If the application is not approved by the DHCFP Central Office Waiver Unit, the following will occur:

- c. A NOD stating the reason(s) for the denial will be sent to the applicant by the DHCFP Central Office Waiver Unit via the DHCFP Hearings and Policy Unit; and
- d. Form NMO-2734 will be sent to ADSD and DWSS by the DHCFP Central Office Waiver Unit stating that the application has been denied and the reason(s) for that denial.

10. If the applicant is denied by ADSD for waiver services, the following will occur:

- a. The ADSD case manager will send an NOA to the DHCFP Central Office Waiver Unit;
- b. The DHCFP Central Office Waiver Unit will send a NOD to the applicant via the DHCFP Hearings and Policy Unit stating the reason(s) why the application was denied by ADSD; and
- c. The DHCFP Central Office Waiver Unit will send Form NMO-2734 to ADSD and DWSS stating that the application was denied and the reason(s) for the denial.

4. Effective Date for Waiver Services

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

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

5. 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 level of care under the state plan that would have been made in that fiscal year, had the waiver not been granted.

2203.14 BILLING PROCEDURES

The State assures that claims for payment of waiver services are made only when an individual is Medicaid eligible, when the service is included in the approved POC, and prior authorization is in place when required.

2203.14A COVERAGE AND LIMITATIONS

All providers (Provider Types 48 and 57) for the HCBW for the Frail Elderly must submit claim forms to the DHCFP's QIO-like vendor. Claims must meet the requirements in the CMS 1500 Claim Form. Claims must be complete and accurate. Incomplete or inaccurate claims will be returned to the provider by the DHCFP's QIO-like vendor. If the wrong form is submitted it will also be returned to the provider by the DHCFP's QIO-like vendor.

2203.14B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.3B, all Providers must:

1. refer to the QIO-like vendor Provider Billing Procedure Manual for detailed instructions for completing and submitting the CMS 1500 form; and
2. maintain documentation to support claims billed for a minimum of six years from the date the claim is paid.

2203.15 ADVANCE DIRECTIVES

Section 1902(w) of the Social Security Act requires licensed provider agencies give their clients information about their decision-making rights about health care, declarations (living wills) and durable powers of attorney for health care decisions. Refer to MSM 100 for further information.

ADSD will provide information on Advance Directives to each applicant and/or the authorized/legal representative. The signed form is kept in each applicant's file at the local ADSD office. Whether an applicant chooses to write his or her own Advance Directives or complete the

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Advance Directives form in full is the individual choice of each applicant and/or each applicant authorized/legal representative.

2203.16 ANNUAL WAIVER REVIEW

The DHCFP and ADSD have formal systems in place to conduct annual reviews. The purpose of the review is to assure the health and welfare of the recipients, the recipients' satisfaction with the waiver services and providers, the qualifications of waiver providers to deliver services/supports, and assurance of the cost effectiveness of these services.

2203.16A COVERAGE AND LIMITATIONS

The State conducts an annual review, which is collaboratively conducted by ADSD and the DHCFP, with the DHCFP being the lead agency. The DHCFP:

1. provides CMS annually with information regarding the impact of the waiver on the type, amount, and cost of services provided under the waiver and under the State plan, and through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of the recipients served on the waiver;
2. assures financial accountability for funds expended for HCBW services;
3. evaluates that all provider standards are continuously met, and that the POCs are periodically reviewed to assure that the services furnished are consistent with the identified needs of the recipients;
4. evaluates the recipients' satisfaction with the waiver program; and
5. further assures that all problems identified by this monitoring will be addressed by the provider in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

2203.16B PROVIDER RESPONSIBILITIES

ADSD and waiver providers must cooperate with the DHCFP's annual review process.

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2204 HEARINGS

2204.1 SUSPENDED WAIVER SERVICES

- A. A recipient's case may 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 a hospital, nursing facility or ICF/MR). After receiving written documentation from the case manager (Form NMO-2734) of the suspension of waiver services, a NOD identifying the effective date and the reason for suspension will be sent to the recipient by the DHCFP Central Office Waiver Unit.
- B. Waiver services will not be paid for the days that a recipient's case is in suspension.
- C. If at the end of the 45 days the recipient has not been removed from suspended status, the case must be closed. ADSD sends a NOA to the DHCFP Central Office Waiver Unit on or before the 45th day of suspension, identifying the 60th day of suspension as the effective date of termination and the reason for the waiver termination.
- D. The DHCFP Central Office Waiver Unit sends a NOD, via the DHCFP Hearings Unit, to the recipient or the recipient's authorized representative advising him or her of the date and reason for the waiver closure/termination.

2204.2 RELEASE FROM SUSPENDED WAIVER SERVICES

If a recipient has been released from the hospital or nursing facility before 60 days have elapsed, within five working days of the recipient's discharge, the case manager must:

- A. assess the LOC for continued eligibility and complete a new form if it appears the recipient no longer meets a LOC;
- B. complete a reassessment if there has been a significant change in the recipient's condition or status;
- C. complete a new POC if there has been a change in services (medical, social or waiver). If a change in services is expected to resolve in less than 30 days, a new POC is not necessary. Documentation of the temporary change must be made in the case manager's notes. The date of resolution must also be documented in the case manager's notes; and
- D. contact the service provider(s) to reestablish services.

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2204.3 DENIAL OF WAIVER APPLICATION

Basis of denial for waiver services:

- A. The applicant is under the age of 65 years.
- B. The applicant does not meet the LOC criteria for nursing facility placement.
- C. The applicant has withdrawn his or her request for waiver services.
- D. The applicant fails to cooperate with ADSD or HCBW service providers in establishing and/or implementing the POC, implementing waiver services or verifying eligibility for waiver services. (The applicant's or their authorized representative's signature is necessary for all required paperwork.)
- E. The applicant's support system is not adequate to provide a safe environment during the time when HCBW services are not being provided.
- F. ADSD has lost contact with the applicant.
- G. The applicant fails to show a need for HCBW services.
- H. The applicant would not require nursing facility placement within 30 days or less if HCBW services were not available.
- I. The applicant has moved out of state.
- J. Another agency or program will provide the services.
- K. ADSD has filled the number of positions (slots) allocated to the HCBW for the Frail Elderly. The applicant has been approved for the waiver wait list and will be contacted when a slot is available.
- L. The applicant is in an institution (e.g. hospital, nursing facility, correctional, ICF/MR) and discharge within 60 days is not anticipated.
- M. The applicant has chosen a provider or facility that is not an enrolled or qualified Medicaid provider.
- N. There are no enrolled Medicaid providers or facilities in the applicant's area.

When the application for waiver services is denied, the case manager sends an NOA to the DHCFP Central Office Waiver Unit. The DHCFP Central Office Waiver Unit sends a NOD to the

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applicant, via the DHCFP Hearings Unit letting them know that waiver services have been denied and the reason for the denial.

2204.4 TERMINATION OF WAIVER SERVICES

Reasons to terminate a recipient from the waiver or to terminate the recipient from the waiver wait list:

- A. The recipient has failed to pay his/her patient liability.
- B. The recipient no longer meets the level of care criteria for nursing facility placement.
- C. The recipient no longer meets other eligibility criteria.
- D. The recipient/authorized representative has requested termination of waiver services.
- E. The recipient has failed to cooperate with ADSD or HCBW service providers in establishing and/or implementing the POC, implementing waiver services, or verifying eligibility for waiver services. (The recipient's or the recipient's authorized representative's signature is necessary on all required paperwork).
- F. The recipient's support system is not adequate to provide a safe environment during the time when HCBW services are not being provided.
- G. The recipient fails to show a continued need for HCBW services.
- H. The recipient is no longer at risk of imminent placement in a nursing facility within 30 days or less if waiver services were not available.
- I. The recipient has moved out of state.
- J. The recipient has signed fraudulent documentation on one or more of the provider time sheets and/or forms.
- K. Another agency or program will provide the services.
- L. The recipient has been, or is expected to be, institutionalized over 60 days (in a hospital, nursing facility, correctional facility or intermediate facility for persons with mental retardation).
- M. ADSD has lost contact with the recipient.
- N. The environment in a residential facility for groups is not safe for the recipient.

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- O. The recipient's swallowing ability is not intact and requires skilled service for safe feeding/nutrition. Residential facilities for groups are not licensed to provide skilled services. Recipients with a g-tube must be competent and manage their tube feeding or they are prohibited by HCQC licensure to be admitted into a residential facility for groups.
- P. The recipient has been placed in a residential facility for groups that does not have a provider agreement with the DHCFP.
- Q. The recipient of a residential facility for groups chooses to return to independent community living which may not be a safe environment.

When a recipient is terminated from the waiver program, the ADSD case manager sends the DHCFP Central Office Waiver Unit an NOA stating the date of termination and the reason(s) for the termination. The DHCFP Central Office Waiver Unit sends a NOD via the Hearings Unit to the recipient or to the recipient's authorized representative. The NOD must be mailed by the DHCFP, Hearings Unit, at least 13 calendar days before the listed date of action on the form. Refer to MSM, Chapter 3100, for specific instructions regarding notice and recipient hearings.

When a termination from waiver services is due to the death of a recipient, the informed agency (ADSD, DHCFP or DWSS) will notify the other two agencies of the date of death.

2204.5 REDUCTION OF WAIVER SERVICES

Reasons to reduce services are:

- A. The recipient no longer requires the number of service hours/level of service which was previously provided.
- B. The recipient no longer requires the service previously provided.
- C. The recipient's support system is capable of providing the service.
- D. The recipient has failed to cooperate with the ADSD case manager or HCBW service provider(s) in establishing and/or implementing the POC, implementing waiver services or verifying eligibility for waiver services (the recipient's or the recipient's authorized representative's signature is necessary on all required paperwork.)
- E. The recipient has requested the reduction of services.
- F. The recipient's ability to perform activities of daily living has improved.
- G. Another agency or program will provide the service.

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

When there is a reduction of waiver services, the updated prior authorization will be submitted and a NOD will be generated. A hearing can be requested through the Hearings Unit by the recipient or the recipient's authorized representative. The form must be mailed by the Hearings Unit to the recipient at least 13 calendar days before the Date of Action on the form.

Refer to MSM Chapter 3100, for specific instructions regarding notice and recipient hearings.

2204.6 REAUTHORIZATION WITHIN 90 DAYS OF WAIVER TERMINATION

2204.6A COVERAGE AND LIMITATIONS

1. If waiver services have been terminated and the recipient is requesting re-approval within 90 days of closure, the recipient still meets a LOC and there is an available waiver slot.

If the termination took place in a prior waiver year and the recipient still meets a LOC, slot availability and emergent need will be taken into consideration for readmission into the waiver.

The ADSD case manager completes and sends to the Medicaid Central Office Waiver Unit the following:

- a. A LOC form;
 - b. Social Health Assessment;
 - c. A new SOU if there has been a change in the authorized/legal representative;
 - d. A new POC if services have changed; and
 - e. A Form NMO-2734 requesting the DHCFP Central Office Waiver Unit approval with the date of approval indicated.
 - f. All required forms must be complete with signatures and dates as applicable.
2. If a recipient is terminated from the waiver for more than 90 days, slots are available and the recipient is eligible for readmission to the waiver as defined in Section 2203.13A.3, a complete waiver packet must be forwarded to the DHCFP Central Office Waiver Unit for authorization.

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2204.6B PROVIDER RESPONSIBILITIES

ADSD will forward all necessary forms to the DHCFP Central Office Waiver Unit for approval.

2204.6C RECIPIENT RESPONSIBILITIES

Recipients must cooperate fully with the reauthorization process to assure approval of his/her request for readmission to the waiver.

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2205 APPEALS AND HEARINGS

Refer to MSM Chapter 3100 for specific instructions regarding notice and hearing procedures.