Medicaid Services Manual
Transmittal Letter

December 26, 2023

To: Custodians of Medicaid Services Manual

From: Casey Angres *Casey Angres* Casey Angres (Jan 23, 2024 12:00 PST)
Chief of Division Compliance

Subject: Medicaid Services Manual Changes
Chapter 2200 – Home and Community Based Services (HCBS) for the Frail Elderly

Background And Explanation

Revisions to Medicaid Services Manual (MSM) Chapter 2200 – Home and Community Based Services (HCBS) for the Frail Elderly (FE) is to move the section and its content related to Electronic Visit Verification (EVV) to new Addendum B.

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: January 1, 2024.

Material Transmitted	Material Superseded
MTL 22/23 MSM Ch 2200 – Home and Community Based Services (HCBS) Waiver for the Frail Elderly	MTL 09/23 MSM Ch 2200 – Home and Community Based Services (HCBS) Waiver for the Frail Elderly

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2203.13	**Electronic Visit Verification (EVV)**	Language removed and replaced with "Refer to Addendum B for more information regarding EVV system requirements."

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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2200 INTRODUCTION

The Home and Community-Based Services (HCBS) Waiver for the Frail Elderly (FE Waiver) recognizes that many individuals at risk of being placed in hospitals or Nursing Facilities (NF) can be cared for in their homes and communities, preserving their independence and ties to family and friends at an average cost no higher than that of an institutional care.

The FE Waiver is an optional service approved by the Centers for Medicare and Medicaid Services (CMS), which authorizes the Division of Health Care Financing and Policy (DHCFP) 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 services as well as certain extended Medicaid covered services. Nevada acknowledges 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.

2201 AUTHORITY

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

Statutes and Regulations:

- Social Security Act: 1915(c) (HCBW)
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- Nevada Revised Statutes (NRS) Chapters 200 (Crimes Against the Person), 426 (Persons with Disabilities), 427A (Services to Aging Persons and Persons with Disabilities), 422 (Health Care Financing and Policy), 449 (Medical and Other Related Facilities), 616 (Industrial Insurance), 629 (Healing and Arts Generally)
- 21st Century Cures Act, H.R. 34, Sec. 12006 – 114th Congress
- Section 3715 of The Coronavirus Aid, Relief, and Economic Security (CARES) Act
- 42 CFR 441.301(c)(4)(i) through (vi) – HCBS Settings Final Regulation
- NRS 449A.114 – Patient Notification of Intent to Transfer
- 42 CFR 441.301(c)(1) through (c)(5) – Federal Person-Centered Planning and Settings Requirements.

2202 RESERVED

2203 POLICY

2203.1 WAIVER ELIGIBILITY CRITERIA

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

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

A. Applicants must be 65 years of age or older.

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

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

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

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

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

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

H. Additional requirements for Residential Facility for Groups and Assisted Living Facility.

1. Applicant/recipient must meet the criteria for placement in a Category 1 or 2 Residential Facility as defined by NAC 449.1591 and 449.1595.

2. Residential Group Homes for Seniors and Assisted Living Facility must have the appropriate endorsement for the admission from Health Care Quality and Compliance (HCQC).

2203.1A COVERAGE AND LIMITATIONS

1. Services are offered to eligible recipients who, without the waiver services, would require institutional care (provided in a hospital or NF) within 30 days or less.

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

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

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

5. Recipients of the HCBS Waiver who are enrolled or elect to enroll in a hospice program may be eligible to remain on the waiver if they require waiver services to remain in the community. Close coordination between the hospice agency and the 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.

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

   a. Identified in an individual's person-centered service 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.

7. The FE Waiver is limited by legislative mandate to a specific number of recipients who can be served through the waiver per year (slots). When no waiver slots are available, the ADSD utilizes a wait list to prioritize applicants who have been presumed to be eligible for the waiver.

8. DHCFP must assure the Center for Medicare and Medicaid Services (CMS) that DHCFP's total expenditure for HCBS and other State Plan Medicaid services for all recipients under this waiver will not, in any calendar/waiver year, exceed 100% of the amount that would

be incurred by DHCFP for all these recipients if they had been in an institutional setting in the absence of the waiver. DHCFP must also document there are safeguards in place to protect the health and welfare of recipients.

2203.1B APPLICANT/RECIPIENT RESPONSIBILITIES

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

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

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

2. Complete and sign all required waiver forms.

2203.2 WAIVER SERVICES

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

2203.2A COVERAGE AND LIMITATIONS

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

1. Case Management.

2. Homemaker Services.

3. Chore Services.

4. Respite Care Services.

5. Home Delivered Meals.

6. Personal Emergency Response System (PERS).

7. Adult Day Care Services.

8. Adult Companion Services.

9. Augmented Personal Care (provided in a residential facility for groups).

2203.2B PROVIDER RESPONSIBILITIES

1. Must obtain and maintain a Medicaid provider number (Provider Type 48, 57, 58 Specialty Code 204 or 59 as appropriate) through DHCFP's Fiscal Agent.

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

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

4. Provider Termination of Waiver Services:

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

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

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

        3. The recipient requests termination of services;

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

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

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

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

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

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

b. Notification Requirements

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

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

5. Discontinuation of Direct Waiver Service Provider Agreement

If a provider decides to discontinue providing waiver services for any reason not listed in 2203.2B(4) – Provider Termination of Waiver Services, the provider shall:

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

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

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

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

7. Flexibility of Service Delivery

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

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

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

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

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

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

    b. The LRI must be an employee of provider agencies PT 48 with SC 039, 191, 199, and 208.

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

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

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

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

14. Serious Occurrence Report (SOR)

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

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

Due to the different databases utilized by case management providers the process for submitting a SOR are as follows:

a. Public ADSD case management:

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

b. Private Case Management (PCM):

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

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

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

Protective Services (APS) (18 years old and above), or law enforcement agencies.

The State of Nevada has established mandatory reporting requirements of suspected incidents or abuse, neglect, isolation, abandonment, and exploitation. APC, DHCFS, and/or local enforcement are the receivers of sub reports. Suspected abuse must be reported as soon as possible, but no later than 24 hours after the person knows or has reasonable cause to believe that a person has been abused, neglected, isolated, abandoned, or exploited. Refer to NRS 200.5091 to 200.50995 "Abuse, Neglect, Exploitation, Abandonment, or Isolation of Older and Vulnerable Persons."

15. Criminal Background Checks

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

DHCFP's fiscal agent will not enroll any provider agency whose owner or operator has been convicted of a felony under State or Federal law for any offense which the DHCFP determines is inconsistent with the best interest of recipients. Additional information may be found in MSM Chapter 100 – Medicaid Program.

16. Recipient Records

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

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

c. Provider agencies who provide waiver services in the home must comply with the 21st Century Cures Act. Refer to Section 2203.13 of this chapter for detailed information.

17. Adhere to HIPAA Requirements.

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

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

19. Providers must obtain and maintain required HCQC license if required.

20. Qualifications and Training:

    a. All service providers must arrange training for employees who have direct contact with recipients of the FE Waiver 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. Record keeping and reporting including daily records and SORs;

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

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

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

2203.2C RECIPIENT RESPONSIBILITIES

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

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

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

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

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

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

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

7. Notify the provider agency or case manager of any missed appointments by the provider agency staff.

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

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

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

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

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

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

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

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

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

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

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

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

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

2203.3 INTAKE ACTIVITIES

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

2203.3A COVERAGE AND LIMITATIONS

1. Intake Referral Process

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

a. Referral/Application

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

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

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

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

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

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

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

Wait List Priority:

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

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

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

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

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

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

3. Waiver Slot Allocation

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

The procedure used for processing an applicant is as follows:

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

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

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

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

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

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

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

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

7. Effective Date for Waiver Services

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

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

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

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

Supporting documents include a signed and dated SOC, a signed and dated HCBS Acknowledgement Form, copy of the ADSD Program Application, copy of the LOC, any

notes from the Intake Specialist needed to support ongoing services, and a copy of the MAABD application submitted to DWSS.

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

2203.4 CASE MANAGEMENT

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

2203.4A COVERAGE AND LIMITATIONS

Case managers must provide the recipient with the appropriate amount of case management services necessary to ensure the recipient is safe and receives sufficient services. case management service is on an as needed basis. case managers must, at a minimum, have an annual face-to-face visit and ongoing contact that is sufficient to meet the needs of the recipient. The amount of case management services must be adequately documented and substantiated by the case manager's notes.

1. Case management is provided to eligible recipients enrolled in HCBS Waiver programs and must be identified as a service on the POC. Case management providers are responsible for confirming the recipient's eligibility each month prior to rendering waiver services. The recipient has a choice of case management providers who are actively enrolled with DHCFP under Provider Type (PT) 48.

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

   Administrative activities include:

   a. Travel

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

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

   d. Any activities related to program eligibility denials/Fair Hearings.

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

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

Billable case management activities include:

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

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

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

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

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

f. Care Conference: collaboration and involvement in discharge planning from a long-term care setting, interdisciplinary meetings, collaboration with other entities on shared cases, coordination of multiple services, and/or providers based on the identified needs in the SHA.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

d. The POC must include the recipient's chosen method and frequency of scheduled contacts (refer to Section 2203.4A(4) – Person Centered contacts for further information on frequency).

e. Changes to the POC

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

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

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

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

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

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

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

h. Residential (RFG and AL Facilities) and Non-Residential (Adult Day Care)

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

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

1. Identify a specific and individualized assessed need;

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

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

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

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

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

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

8. Include the informed consent of the individual.

4. Person-Centered Contacts

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

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

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

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

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

a. Quality of care included the identification, remediation, and follow-up of health and safety, risk factors, needs and concerns (to include changes in provider and/or back-up plan or support network) of the recipient, waiver service, satisfaction and whether the services are promoting the personalized goals stated in the POC. The case

manager also assesses the need for any change in services or providers.

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

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

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

5. Annual Reassessments

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

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

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

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

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

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

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

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

7. Ensure recipients retain freedom of choice in the provision of services. During the ongoing contact with the recipient the case manager must narrate if a recipient indicates that they are not satisfied with their current waiver services.

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

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

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

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

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

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

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

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

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

2203.4B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.2B: must:

1. Public case managers must meet the following qualifications:

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

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

   c. Adhere to HIPAA requirements.

   d. Complete an FBI criminal background check.

2. Private case management provider agencies must:

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

   b. Provide proof of Nevada Secretary of State Business license.

   c. Provide proof of Worker's Compensation Insurance.

   d. Provide proof of an Unemployment Insurance Account.

   e. Provide proof of Commercial General Liability of not less than $2 million general aggregate and $1 million each occurrence, with Nevada DHCFP named as an additional insured. DHCFP's address is 1100 East William Street, Suite 101, Carson City, Nevada 89701.

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

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

      1. Proof of Business Automobile Insurance, with a minimum coverage of $750,000 combined single limit for bodily injury and property damage for any owned, leased, hired, and non-owned vehicles used in the performance of the Medicaid provider's contract. The policy must name DHCFP as an

additional insured and shall be endorsed to include the following language. "The State of Nevada shall be named as an additional insured with respect to liability arising out of the activities performed by, or on behalf of the Contractor, including automobiles owned, leased, hired, or borrowed by the Contractor."

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

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

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

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

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

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

3. Adhere to HIPAA requirements.

4. Complete an FBI criminal background check.

2203.4C RECIPIENT RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2203.2C, the recipient must:

1. Participate in the ongoing contacts and reassessment process, accurately representing their skill level needs, preferences, resources, and goals.

2. Together with the case manager, develop and/or review, sign, and the date the POC. If the recipient is unable to provide a signature due to cognitive and/or physical limitations, this will be clearly documented in the recipient file.

3. Choose a Medicaid enrolled case management provider.

2203.5 HOMEMAKER SERVICES

Homemaker services consist of IADLs such as general household tasks, meal preparation, shopping, and laundry. These services are provided when the individual regularly responsible for these activities is temporarily absent or unable to manage their private residence and is necessary to avoid placement in an institution.

2203.5A COVERAGE AND LIMITATIONS

1. Homemaker services are provided at the recipient's home, or place of residence (community setting).

2. Services must be directed to the individual recipient and related to their health and welfare.

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

4. Homemaker services include:

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

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

    c. Meal preparation menu planning, storing, preparing, serving food, buttering bread, and plating food;

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

    e. Assisting the recipient and family members or caregivers in learning a homemaker routine and skills so the recipient may carry on normal living when the homemaker is not present;

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

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

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

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;

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

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

2203.5B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.2B, Homemaker Providers must:

1. Provide adequate training related to homemaking assistance appropriate for recipients on the FE Waiver completed initially and annually;

2. Ensure that EVV requirements and expectations are met, including the documentation of all services in approved EVV system; and

3. The service must be prior authorized and documented in an approved EVV System.

2203.5C RECIPIENTS RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2203.2C, the recipient must:

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

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

2203.6 CHORE SERVICES

Chore services are intermittent in nature and may be authorized as a need arises for the completion of a specific task which otherwise left undone poses a home safety issue. These services are provided only in cases where the recipient, anyone else in the household, landlord, community volunteer/agency, or third-party payer is not capable of performing nor responsible for, the provision of these services or financially able to provide the services and without these services, the recipient would be at risk of institutionalization.

2203.6A COVERAGE AND LIMITATIONS

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

2. This service includes heavy household chores such as:

   a. cleaning windows and walls;

   b. shampooing carpets; tacking down loose rugs and tiles;

   c. moving heavy items of furniture to provide safe access;

   d. packing and unpacking for the purpose of relocation;

   e. minor home repairs; or

   f. removing trash and debris from the yard.

3. This is not a skilled, professional service.

4. In the case of rental property, the responsibility of the landlord pursuant to the lease

agreement, must be examined and confirmed prior to any authorization of service. The legal responsibility of the landlord to maintain and ensure safety on the rental property shall supersede any waiver covered services.

2203.6B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.2B, individuals performing chore services must:

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

2. Maintain the home in a clean, sanitary, and safe environment if performing heavy household chores and minor home repair services;

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

4. Services must be prior authorized and documented in an approved EVV system.

2203.6C RECIPIENT RESPONSIBILITIES

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

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

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

2203.7 RESPITE CARE

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

2203.7A COVERAGE AND LIMITATIONS

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

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

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

2203.7B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.2B, Respite Providers must:

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

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

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

2203.7C RECIPIENTS RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2203.2C, the recipient must:

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

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

2203.8 HOME DELIVERED MEALS

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

2203.8A COVERAGE AND LIMITATIONS

Recipients who require home delivered meals are unable to prepare or obtain nutritional meals without assistance or are unable to manage a special diet recommended by their physician.

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

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

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

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

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

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

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

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

2203.8B PROVIDER RESPONSIBILITIES

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

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

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

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

2203.8C RECIPIENT RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2203.2C, the recipient must:

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

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

2203.9 PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)

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

2203.9A COVERAGE AND LIMITATIONS

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

2. The initial installation fee for the device and a monthly fee for ongoing monitoring are covered under this service.

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

2203.9B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.2B, PERS Providers must:

1. Ensure that the response center is staffed by trained professionals at all times;

2. Complete any replacement or repair needs that may occur and monthly monitoring to ensure the device is working properly;

3. Devices must meet Federal Communication Commission standards, Underwriter's Laboratory, Inc. (UL) standards or equivalent standards;

4. Inform recipients of any liability they may incur as a result of the disposal or loss of provider property.

5. This service must be prior authorized by the case manager.

2203.9C RECIPIENT RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2203.2C, the recipient must:

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

2. Return the equipment to the provider when it is no longer needed or utilized, or when the recipient terminates from the waiver program.

3. Not dispose of or damage the PERS equipment. This is leased equipment and belongs to the PERS provider.

2203.10 ADULT DAY CARE SERVICES

Adult Day Care services are provided in a non-institutional community-based setting, including outpatient settings. It encompasses social service needs to ensure the optimal functioning of the recipient. The emphasis is on social interaction in a safe environment.

2203.10A COVERAGE AND LIMITATIONS

1. It is provided on a regularly scheduled basis in accordance with the goals in the POC and must indicate the number of days per week the recipient will attend.

2. The case manager may authorize up to a maximum of six hours per day.

3. If the recipient's overall pattern changes and consistently attends less than six hours a day, a change to the POC and PA will be required.

4. Meals provided are furnished but must not constitute a "full nutritional regimen" (i.e., three meals per day). Meals must be served in a manner suitable for the recipient and prepared with regard for individual preferences. Special diets and nourishments must be provided as ordered by the client's physician.

5. Providers must not bill for days a recipient is not in attendance, even if it is a regularly scheduled day.

2203.10B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.2B, Adult Day Care Providers must:

1. Bill the per diem rate if the recipient is in attendance for a maximum of six hours per day. If the authorized hours for attendance is less than six hours then bill the unit rate.

2. Provider must bill in accordance with the approved PA, even if the recipient occasionally attends less than six hours a day.

3. Providers must keep attendance records for each recipient. Claims must reflect dates and times of service as indicated on the attendance records.

2203.11 ADULT COMPANION SERVICES

Adult Companion Services provides non-medical care, supervision and socialization to a functionally impaired recipient in his or her home or place of residence, which are furnished on a short-term basis or to meet the need for relief for the primary caregiver.

2203.11A COVERAGE AND LIMITATIONS

1. Adult companions may assist or supervise the recipient with 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 Day Care Services and must be incidental to the care and supervision of the recipient.

2. The provision of Adult Companion Services does not entail hands-on medical care.

3. This service is provided in accordance with the personalized goal in the POC and is not purely diversional in nature.

4. Transportation is not a covered service. Reference MSM Chapter 1900 Transportation Services for transportation policies.

5. LRIs are allowed to provide this service only when no other similar services are in place such as Adult Day Care or living in a residential group home. Limit to two hours/day and is based on the case manager's assessment and only if the primary and live-in caregiver needs a break or to run errands, etc.

2203.11B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.2B, 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 and various health 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.

2203.11C 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.

2203.12 AUGMENTED PERSONAL CARE

Augmented Personal Care (APC) provided in a licensed Residential Facility for Groups (RFG) or Assisted Living (AL) Facility setting that meets the HCBS settings requirements in a 24-hour in home service that provides assistance for elderly recipients with basic self-care and ADLs that include as part of the service:

A. Homemaker Services;

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 RFG or AL Facility.

2203.12A COVERAGE AND LIMITATIONS

1. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence; and provides supervision, safety, and security.

2. Once a FE Waiver recipient/applicant expresses an interest in an RFG setting, they are provided with a list of qualified providers. A case manager is available to provide additional information and guidance related to the individual's specific needs. Consideration may include size of the home, geographic location, proximity to friends and family, available support, activities, food, staff, other residents, likes and dislikes, medical or mental health concerns, whether pets are allowed, and a variety of other individualized preferences.

3. There are four service levels of APC. The service level provided is based on the recipient's functional needs to ensure the recipient's health, safety, and welfare. The case manager determines the service level:

   a. Level One Daily (minimum assistance)

      This level provides supervision and cueing to complete basic self-care and ADLs. In home supervision is available when direct care tasks are not being completed.

   b. Level Two Daily (moderate assistance)

      This level provides physical assistance with moderate hands-on care of basic self-care and ADLs. Some basic self-care may require a moderate level of assistance. This service provides in-home supervision with regularly scheduled checks as needed.

   c. Level Three Daily (maximum assistance)

      This level provides physical assistance to complete basic self-care and ADLs. With maximum hands-on care. Direct 24-hour supervision and/or safety system (alarm) to ensure safety when supervision is not direct. It includes daily home making for clean up after basic self-care tasks, weekly homemaking for general cleaning, and up to twice daily assistance with meal preparation.

   d. Level Four (Critical Behaviors)

      In addition to meeting a level one, two or three for ADLs/IADLs care, level 4 requires substantial and/or extensive assistance with critical behaviors: Behavioral Problems, Resists Care, Socially Inappropriate, Wandering, Physically Abusive to self and/or others, Verbally Abusive, and behaviors that represent a safety risk. Requiring the full attention of staff members when behaviors are present and/or presents a need for additional staffing to redirect and address behaviors. Additional documentation and agency approval required.

      Documentation on the daily log for at least 60 days is required to justify amount and types of care for service level determination and verification of proper billing.

   All four service levels provide help with laundry; housekeeping; meal preparation and eating; bed mobility and transfers; bathing, dressing, and grooming; mobility and ambulation; and access to social and recreational programs. The service level determines the amount, duration and frequency of the services provided.

   All service levels are reassessed annually, or as significant changes occur, and may increase or decrease to reflect the recipient's current level of need.

Documentation on the daily log is required to justify amount and types of care for service level determination and verification of proper billing.

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

5. 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 RFG or AL Facility. However, the care provided by these other entities supplements what is being provided but does not supplant it.

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

2203.12B PROVIDER RESPONSIBILITIES

In addition to the responsibilities listed in Section 2203.2B providers must:

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

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

3. The provider for a RFG or AL Facility must:

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

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

   c. Participate with the case manager in discharge planning.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. Recipient Records

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

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

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

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

d. Services for waiver recipients residing in a RFG or AL Facility should be provided as specified on the POC and at the appropriate authorized service level.

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

2203.12C RECIPIENT RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in Section 2203.2C, the recipient must:

1. Recipients are to cooperate with the providers of RFG or AL Facility in the delivery of services.

2. Recipients are to report any problems with the delivery of services to the RFG or AL Facility administrator and/or case manager.

2203.13 ELECTRONIC VISIT VERIFICATION (EVV)

Refer to Addendum B for more information regarding EVV system requirements.

2203.14 DHCFP LTSS INITIAL REVIEW

Once the applicant has been approved for the waiver, DHCFP LTSS will review all initial eligibility packets for completeness to ensure waiver requirements are being met. The eligibility packet for review must include:

1. The NF LOC screening to verify the applicant meets NF LOC criteria;

2. At least one waiver service identified:
3. The SOC complete with signature and dates; and

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

NOTE: Electronic signatures are acceptable pursuant to NRS 719.350 "Acceptance and distribution of electronic records by governmental agencies" on forms that require a signature.

2203.15 WAIVER COSTS

DHCFP must assure CMS that the average per capita expenditures under the waiver will not exceed 100% of the average per capita expenditures for the institutional LOC under the state plan that would have been made in that fiscal year, had the waiver not been granted.

2203.16 QUALITY ASSURANCE WAIVER REVIEW

The state conducts an annual review of active waiver participants. CMS has designated waiver assurances and sub-assurances that states must include as part of an overall quality improvement strategy. The annual review is conducted using the state specified performance measures identified in the approved FE Waiver to evaluate operation.

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

2203.17 PROVIDER ENROLLMENT

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

2203.18 BILLING PROCEDURES

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

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

2203.19 ADVANCE DIRECTIVES

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

The case manager must provide information on Advance Directives to each recipient and/or designated representative/LRI during the initial assessment and annually thereafter. The signed Acknowledgement form is kept in each recipient's file at the local ADSD office. Whether a recipient chooses to write their own Advance Directives or complete an Advance Directives form in full is the individual choice of each applicant and/or designated representative/LRI.

2204 HEARINGS REQUESTS DUE TO ADVERSE ACTIONS

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

2204.1 SUSPENDED WAIVER SERVICES

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

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

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

3. If the recipient continues to be institutionalized for 45 days, on the 46th day, the case manager will request DHCFP LTSS to send a termination NOD to the recipient indicating termination from the waiver on the 61st day from the admission date.

2204.2 RELEASE FROM SUSPENDED WAIVER SERVICES

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

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

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

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

2204.3 DENIAL OF WAIVER ELIGIBIITY

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 NF placement.

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

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

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

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

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

H. The applicant would not require NF placement within 30 days or less if waiver 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. The applicant has been approved for the waiver wait list and will be contacted when a slot is available.

Wait List Priority:

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

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

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

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

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

M. The applicant is in an institution (e.g. hospital, NF, correctional facility, ICF/IID) and discharge within 60 calendar days is not anticipated.

N. The applicant has chosen a provider or facility that is not an enrolled or qualified Medicaid provider. Note: The case manager should provide a list of Medicaid providers to the applicant. The case manager will inform the provider that all entities providing services must be enrolled as a Medicaid provider and facilitate contact information to the DHCFP's Fiscal Agent.

When the application and/or request for waiver services is denied, the case manager will send a NOD request to the DHCFP LTSS Unit. The DHCFP LTSS Unit sends a NOD to the applicant/recipient informing them of the reason for the denial.

2204.4 REDUCTION OR DENIAL OF DIRECT WAIVER SERVICES

Basis of reduction or denial of direct waiver services:

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

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

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

D. The recipient does not demonstrate a need or have the capacity/ability for the requested waiver services.

NOTE: A reduction includes when a specific waiver service's hours are reduced to zero.

When there is a reduction of waiver services, the case manager will identify the reason for the reduction and what the service will be reduced to and request the DHCFP LTSS Unit to send a NOD. DHCFP LTSS will issue a reduction NOD indicating the reason and the date of action which is at least 13 calendar days from the notice date. Refer to MSM Chapter 3100 Hearings, for specific instructions regarding notification and recipient hearings.

When the request for a direct waiver service(s) is denied, the case manager will send a NOD request to the DHCFP LTSS Unit. The DHCFP LTSS Unit sends a NOD to the applicant/recipient informing them of the reason for denial.

2204.5 TERMINATION OF WAIVER PROGRAM ELIGIBILITY

Reasons to terminate authorized waiver services and/or eligibility from the waiver program:

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

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

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

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

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

F. The recipient has moved out of state.

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

H. Another agency or program will provide the services.

I. The recipient has been, or is expected to be, institutionalized over 60 days (in a hospital, NF, correctional facility, or ICF/IID.

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

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

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

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

N. The physical environment in a residential facility for groups is not safe for the recipient's individual health condition.

O. The recipient's swallowing ability is not intact and requires skilled service for safe feeding/nutrition. Residential Facility for Groups are not licensed to provide skilled services. Recipients with a gastrostomy-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 DHCFP. Note: The case manager should work with the provider

before terminating the recipient waiver services, explain that all entities providing services must be enrolled as a Medicaid provider and facilitate contact information to DHCFP's Fiscal Agent.

Q. The recipient of a residential facility for groups chooses to return to independent community living which may not be a safe environment.

R. Death of recipient.

When a recipient is terminated from the waiver program, the case manager will request the DHCFP LTSS Unit to send a NOD. DHCFP LTSS will issue a termination NOD indicating the reason and the date of action which is at least 13 calendar days from the notice date. Refer to MSM, Chapter 3100 – Hearings, for specific instructions regarding notice and recipient hearings.

2204.6 REAUTHORIZATION WITHIN 90 DAYS OF WAIVER TERMINATION

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

2204.6A COVERAGE AND LIMITATIONS

1. The waiver slot must be held for 90 days from date of action listed on the NOD.

2. The recipient may request to be placed back on the waiver if:

   a. They still meet LOC; and

   b. They are released/discharged within 90 days.

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

2204.6B PROVIDER RESPONSIBILITIES

The last known case management provider is responsible for resuming case management responsibilities for the recipient within three business days, to include the following:

1. Contact DWSS via the NMO-3010 to reinstate eligibility;

2. Contact DHCFP LTSS Unit via the NMO-3010 to reinstate the wavier benefit line;

3. Contact ADSD Operations Agency to notify of the reinstatement of waiver slot placement; and

4. Notify all direct waiver service providers of waiver reinstatement.

   If the case manager determines that there has been a significant change in the recipient's condition as appropriate, refer to MSM Section 2203.4A(3)(e). for requirements.

2204.6C RECIPIENT RESPONSIBILITIES

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

2. If the recipient is discharged after the 90th day from the date of action on the NOD, they must reapply for wavier services.

2205 APPEALS AND HEARINGS

Refer to MSM Chapter 3100 for specific instructions regarding notice and hearing procedures. Recipients are informed of their rights to a fair hearing at the initial face-to-face visit and annually thereafter when they are given the Recipients Rights Form.