MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

November 8, 2011

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: MARTA E. STAGLIANO, CHIEF, COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 3900 – HOME AND COMMUNITY BASED WAIVER (HCBW) FOR ASSISTED LIVING

## BACKGROUND AND EXPLANATION

Medicaid Services Manual (MSM) Chapter 3900, Home and Community Based Waiver (HCBW) for Assisted Living, has been revised to remove the Definitions and References/Cross References sections. The Definitions were moved to the MSM Addendum and the References/Cross References to MSM Chapter 100.

These policy changes are effective November 9, 2011.

| MATERIAL TRANSMITTED | MATERIAL SUPERSEDED |
|---|---|
| MTL 30/11<br>CHAPTER 3900 – HOME AND COMMUNITY BASED WAIVER (HCBW) FOR ASSISTED LIVING | MTL 29/10<br>CHAPTER 3900 – HOME AND COMMUNITY BASED WAIVER (HCBW) FOR ASSISTED LIVING |

| Manual Section | Section Title | Background and Explanation of Policy Changes, Clarifications and Updates |
|---|---|---|
| **3902** | **Reserved** | Removed Definition Section. |
| **3905** | **References and Cross References** | Removed References. |

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HOME AND COMMUNITY-BASED WAIVER (HCBW) FOR ASSISTED LIVING

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# 3900 INTRODUCTION

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

Division of Health Care Financing and Policy's (DHCFP) AL Waiver originated in 2006. The provision of the AL Waiver services is based on the identified needs of the waiver recipient. Every biennium, the service needs and the funded slot needs of the AL Waiver are reviewed by the Aging and Disability Services Division (ADSD) and the DHCFP, and presented to the Nevada State Legislature for approval. The state of Nevada is committed to the goal of providing the elderly with the opportunity to remain in a community setting in lieu of institutionalization and to be self sufficient. The state of Nevada also understands that people who are elderly are able to lead satisfying and productive lives when appropriate services and supports are provided.

# 3901 AUTHORITY

Section 1915(c) of the Social Security Act permits states to waive certain Medicaid statutory requirements in order to offer an array of home and community-based services that an individual requires to remain in a community setting and avoid institutionalization. The Home and Community-Based Waiver for Assisted Living (AL Waiver) is an optional program approved by the Centers for Medicare and Medicaid Services (CMS). The AL Waiver is designed to provide Medicaid State Plan services and certain extended Medicaid covered services unique to this waiver to eligible Medicaid waiver recipients. The goal is to allow recipients to live in a community setting when appropriate.

Nevada has the flexibility to design the AL Waiver and select the mix of Home and Community-Based Waiver (HCBW) services that best meet the goal to keep people in the community. Such flexibility is predicated on administrative and legislative support as well as federal approval.

**Statutes and Regulations:**

- Social Security Act: 1915(c) (Home and Community-Based Waiver)
- Social Security Act: 1916(e) (No denial for inability to share costs)
- Social Security Act: 1902(w) (Eligibility)
- Omnibus Budget Reconciliation Act of 1987
- Balanced Budget Act of 1997
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- State Medicaid Manual, Section 4440 (Home and Community-Based Waiver, Scope, and Purpose
- Title 42 Code of Federal Regulations (CFR) Part 431, Subpart B (General Administrative Requirements)
- Title 42 CFR Part 431, Subpart E (Fair Hearings for Applicants and Recipients)
- Title 42 CFR 440.40
- Title 42 CFR 440.169 (Case Management Services)

- Title 42, CFR Part 441, Subparts G and H (Home and Community-Based Services: Waiver Requirements; Home and Community-Based Services Waivers for Individuals Age 65 or Older: Waiver Requirements)

- Title 42 CFR 441.305(a) (Replacement of Recipients in Approved Waiver Programs)

- Title 42 CFR 489, Subpart I (Advance Directives)

- Title 42 CFR 440.155 (Nursing Facility Services)

- Nevada's Home and Community-based AL Waiver Control Number 0452

- Nevada Revised Statutes (NRS) Chapters 200 ( Crimes Against the Person); 232 (Department of Health and Human Services); 319 (Assistance to Finance Housing); 422, (Health Care Financing and Policy); 427A (Services to Aging Persons); 439 (Fund for a Healthy Nevada); 449 (Medical and Other Related Facilities); 616A (Industrial Insurance Administration); 629 (Healing Arts Generally)

- Nevada Administrative Code (NAC) Chapters 427A (Services to Aging Persons), 449 (Medical and Other Related Facilities); 441A.375 (Tuberculosis)

3902 RESERVED

## 3903 POLICY

The Home and Community-Based Waiver (HCBW) for Assisted Living (AL Waiver) waives certain statutory requirements and offers HCBW services to all recipients enrolled in this waiver to assist them to remain in the community.

Division of Health Care Financing and Policy (DHCFP) must provide assurance to Centers for Medicare and Medicaid Services (CMS) that the state's total expenditures for HCBW services and other Medicaid State Plan services for all recipients will not exceed, in any waiver year, 100 percent of the amount that would be incurred by Medicaid for all these recipients in an institutional setting in the absence of the waiver. DHCFP must also document that there are safeguards in place to protect the health and welfare of recipients.

## 3903.1 ADMINISTRATIVE CASE MANAGEMENT ACTIVITIES

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

## 3903.1A COVERAGE AND LIMITATIONS

1. Intake referral;

2. Facilitating Medicaid eligibility, which may include assistance with the Medical Assistance to the Aged, Blind and Disabled (MAABD) application, obtaining documents required for eligibility determination;

3. Provision of the written POC document to the Assisted Living provider;

4. Complete prior authorization form prior to submission to Medicaid Management Information Systems (MMIS);

5. Determine cost effectiveness of waiver services for each applicant;

6. Monitor Assisted Living providers to assure compliance with the AL Waiver provider goals and provision of services;

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

    a. Complete recipient's reassessment of the LOC, functional status and needs addressed by the POC annually or more often as needed. The recipient must also

be reassessed when there is a significant change in his/her condition which influences eligibility. The reassessment should be conducted during a face-to-face visit.

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

8. Arrange for the relocation of the recipient, if necessary, when an alternative placement is requested or needed;

9. Issuance of Notices of Actions (NOA) to DHCFP Central Office Waiver Unit staff, to issue a Notice of Decision (NOD) when a waiver application is denied;

10. Outreach activities to educate recipients or potential recipients on how to enter into care through a Medicaid program;

11. Documentation for case files prior to recipient eligibility;

12. Case closure activities when the recipient's waiver eligibility is terminated; and

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

3903.1B ADMINISTRATIVE CASE MANAGEMENT PROVIDER RESPONSIBILITIES

1. Possess current licensure as a social worker or associate in Social Work from the Nevada Board of Examiners for Social Workers, or meet the criteria for licensure as a social worker but currently licensed in another capacity which qualifies for exemption per NRS 641.040, or who has licensure as a Registered Nurse from the Nevada State Board of Nursing.

2. Have, or be supervised by someone who has one year of experience working with seniors in a home-based environment.

3. Conform to Health Insurance Portability and Accountability Act (HIPAA) of 1996 requirements.

3903.1C ADMINISTRATIVE CASE MANAGEMENT RECIPIENT RESPONSIBILITIES

The applicant/recipient will cooperate in the assessment/reassessment process as well as participate in the development and review of the POC. The applicant/recipient or his/her legally responsible individual or authorized representative must sign the POC.

3903.2 ELIGIBILITY CRITERIA

Recipients must meet and maintain all criteria to be eligible during the period of time the recipients receive services under the auspices of the AL Waiver.

Eligibility for the AL Waiver is determined by the combined efforts of the DHCFP, ADSD, and the Division of Welfare and Supportive Services (DWSS). These three state agencies collaboratively determine eligibility.

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

B. Applicant/recipient must meet and maintain a level of care category for admission to a nursing facility. If the AL Waiver services or other supports were not available, the applicant/recipient would require imminent placement in a nursing facility (within 30 days). The administrative case manager assesses a LOC according to the guidelines specified in Medicaid Services Manual Chapter 500.

C. Applicants/recipients must demonstrate a continued need for the AL Waiver services to prevent placement in a nursing facility or other institutional setting. Utilization by the applicant/recipient of Medicaid State Plan services only is not in itself sufficient to support the eligibility of the applicant/recipient for AL Waiver services.

D. Applicants who are currently in an acute care facility, a nursing facility, in another HCBW, or in the community may be evaluated for the AL Waiver services.

E. Financial eligibility for Medicaid benefits is determined by DWSS.

F. Recipients must be Medicaid eligible each month in which AL Waiver services are provided.

G. DHCFP Central Office Waiver Unit reviews and authorizes all waiver applications prior to the start of service provision.

H. Services cannot be provided nor be reimbursed by DHCFP until and unless the applicant is found eligible in all three determination areas, as established by ADSD, DHCFP, and DWSS.

3903.2A COVERAGE AND LIMITATIONS

1. Services are offered to eligible applicants who, without waiver services, would require institutional care provided in a hospital or nursing facility within 30 days or less.

2. Recipients on this waiver must maintain Medicaid eligibility requirements.

3. The AL Waiver is limited by legislative authority to a specific number of recipients who can be served through the waiver per year (slots). When all waiver slots are filled, a wait list is utilized to prioritize applicants who have been screened for waiver eligibility.

4. The Wait List is managed based on priority, slot availability, available budget authority, and date the waiver application is received by ADSD.

   Applicants who, at the time of application, are in a nursing facility or an acute care setting will be prioritized and processed before those applicants placed on the Wait List by date of application. This priority facilitates the provision of services in the most integrated setting appropriate to the needs of the applicant.

5. Waiver services may not be provided while a recipient is an inpatient of any institution.

6. Applicants must require the provision of one waiver service at least monthly to be determined eligible for the AL Waiver.

7. Recipients of the AL 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 case coordination between the hospice agency and the waiver case manager is required to prevent any duplication of services. Refer to Medicaid Services Manual (MSM) Chapter 3200 for additional information on hospice services.

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

3903.2B PROVIDER RESPONSIBILITIES

1. All waiver service providers, including case managers, are responsible for verifying the Medicaid and the AL Waiver eligibility monthly.

2. Providers are responsible for maintaining all required provider qualifications per DHCFP and ADSD policy.

3. Providers are responsible for assuring prior authorization is established prior to initiating services.

3903.2C RECIPIENT RESPONSIBILITIES

Recipients/applicants must meet and maintain all eligibility criteria to be eligible for and to remain on the AL Waiver.

3903.3 AL WAIVER SERVICES

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

3903.3A COVERAGE AND LIMITATIONS

Under this waiver, the following services are provided as necessary to avoid institutionalization:

1. Direct Service Case Management:

   Direct service case management is a service which assists individuals who receive waiver services in gaining access to needed waiver and other State Plan services, as well as needed medical, social, educational services regardless of the funding source for the services to which access is gained.

2. Augmented Personal Care Services:

   Augmented Personal Care Services provided by Assisted Living Facilities include assistance with basic self care and activities of daily living (ADL), homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, and services which will ensure that the residents of the facility are safe, secure, and adequately supervised. This care is over and above the mandatory service provision required by regulation for residential facilities for groups. There are three levels of augmented personal care based on the recipient's functional status.

3903.3B ALL PROVIDER RESPONSIBILITIES

1. All providers may only provide services identified in the recipient's POC. For those services requiring prior authorization, a prior authorization must be obtained before service provision.

2. Payment for services will be based on the level of care and the specific tasks identified on the POC.

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

4. Providers must have a file for each recipient. In the recipient's file, the provider must have a copy of the current POC and maintain daily records, fully documenting the scope and frequency of services as specified on the POC. The daily record is documentation completed by a provider, indicating the scope and frequency of services provided. The documentation will include the recipient's initials daily with a full signature of the recipient on each record. If the recipient is unable to provide a signature due to cognitive and/or physical limitations, this will be clearly documented in the recipient file. The provider will initial after the daily services are delivered, with a full signature of the provider on each daily record. Providers may use electronic signatures on the daily record documentation, but using an electronic signature does not remove the provider's responsibility for providing accurate and verifiable documentation indicating the scope and frequency of the services provided. If a provider elects to use electronic signatures, they must have weekly printouts of the daily record in the recipient's file. Periodically, DHCFP Central Office staff may request this documentation to compare it to billings submitted. These records must be maintained by the provider for at least six years after the date the claim is paid.

5. Criminal Background Checks:

   Under NRS 449.176 through NRS 449.188, people who have been convicted of certain crimes may not work at certain long term care facilities or agencies. The complete statute is available at http://leg.state.nv.us/NRS/NRS-449.html and the requirements applying to the providers are discussed at length at the Bureau of Health Care Quality and Compliance (HCQC) website: http://health.nv.gov/HCQC_CriminalHistory.htm.

   All agency personnel, including owners, officers, administrators, managers, employees and consultants must undergo State and FBI background check upon licensure as a provider and then at a minimum of every five (5) years thereafter to ensure no convictions of applicable offenses have been incurred.

   Documentation of the request, and applicable results, must be maintained in each employee personnel record and made available to DHCFP upon request. Providers must have the criminal background check through the Nevada Department of Public Safety (DPS) initiated by the hiring/employing agency prior to providing any Medicaid reimbursable services to a recipient.

   Providers are required to initiate diligent and effective follow up for results of background checks within 90 days of submission of prints and continue until results are received. This is particularly important when an "undecided" result is received. Documentation must be maintained in the employee's personnel file and submitted to DHCFP upon request.

a. The DHCFP or their designee will not enroll any person or entity convicted of a felony or misdemeanor for any offense which the State agency determines is inconsistent with the best interests of recipients. Such determinations are solely the responsibility of DHCFP.

b. The DHCFP applies the requirements of NRS 449.176 through NRS 449.188 and will deny a provider contract to any applicant, or may suspend or revoke all associated provider contracts of any provider, to participate in the Medicaid program if the requirements of the referenced NRS sections are not met. In addition, see MSM Chapter 100.

1. If the provider receives information related to NRS 449.176 through NRS 449.188 resulting from the criminal background check or from any other source and continues to employ a person who has been convicted of an offense as listed above, DHCFP will take appropriate action, which may include suspension or termination of the agency's Medicaid provider contract.

2. If the hiring/employing agency does not take timely and appropriate action on the results of the background check as defined in NRS 449.176 through NRS 449.188 and on the HCQC website, DHCFP will take appropriate action, which may include suspension or termination of the agency's Medicaid provider contract.

c. If an employee believes that the information provided as a result of the criminal background check is incorrect, the individual must immediately inform the employing agency and DHCFP in writing. Information regarding challenging a disqualification is found on the HCQC website at: http://health.nv.gov/HCQC_CriminalHistory.htm.

6. Serious Occurrence Report (SOR):

Providers must report any recipient incidents, or issues regarding the provider/employee's ability to deliver services to the ADSD case manager by telephone/fax within 24 hours of discovery. A completed SOR form must be made within five (5) working days and maintained in the agency's recipient record.

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

a. Suspected physical or verbal abuse;

b. Unplanned hospitalization;

c. Neglect of recipient;

d. Exploitation;

e. Sexual harassment or sexual abuse;

f. Injuries requiring medical intervention;

g. An unsafe working environment;

h. Any event which is reported to Child or Elder Protective Services or law enforcement agencies;

i. Death of the recipient during the provision of services;

j. Medication error;

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

The State of Nevada has established mandatory reporting requirements of suspected incidents of elder abuse. Refer to Section 3904.1 regarding elder abuse and neglect.

7. Aging and Disability Services Division (ADSD):

Maintains compliance with the Interlocal Agreement with DHCFP to operate the AL Waiver.

8. Assisted Living Providers:

a. Providers are responsible for maintaining certification, including the use of tax credits, as an assisted living facility in accordance with the provisions of NRS 319.147.

b. Training:

1. Assisted Living providers must arrange training for employees who have direct contact with the AL Waiver recipients. Assisted Living staff providing direct care and support to residents will be trained in the functional care skills needed to care for each recipient. Training will include, but not be limited to, techniques such as transfers, mobility, positioning, use of special equipment, identification of signs of distress, First Aid and cardiopulmonary resuscitation (CPR).

2. Within 60 days of employment, the Assisted Living staff must receive not less than 4 hours of training related to the care of the residents. Additionally, Assisted Living staff must receive annually not less than eight (8) hours of training related to providing for the needs of the residents of the Assisted Living facility.

3. If an Assisted Living staff assists a resident of the Assisted Living facility in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver must receive training in medication administration/management. The training must include not less than three (3) hours of instruction in medication administration/management. The caregiver must receive such training at least every three (3) years, and must provide the facility with the documentation that the training requirements were satisfactorily met.

For more information regarding qualifications and training for caregivers in a residential/assisted living facility, refer to NAC 449.196.

c. Interpersonal and communication skills and appropriate attitudes for working effectively with recipients including: understanding care goals; respecting recipient's rights and needs; respect for age, cultural and ethnic differences; recognizing family relationships; respecting personal property; ethics in dealing with the recipient, family and other providers; handling conflicts and complaints and other topics that are pertinent.

d. Assisted Living staff providing direct care and support to recipients must: be at least 18 years of age, be responsible, mature, and have the personal qualities enabling him or her to understand the problems of the aged and disabled; demonstrate the ability to read, write, speak and understand the English language; possess the appropriate knowledge, skills and abilities to meet the needs of the residents of the Assisted Living facility; and must be knowledgeable about the use of any prosthetic devices or dental, vision, or hearing aids that the recipient is using.

e. Tuberculosis Testing:

Providers are responsible for ensuring that their employees complete either a QuantiFERON®-TB Gold blood test (QFT-G) or a two step (TB) Tuberculin skin test prior to initiation of services for the AL Waiver recipients. Thereafter, each employee must receive a QFT-G blood test or a one step TB skin test annually, prior to the expiration of the initial test. If the employee has a documented history of a positive QFT-G or TB skin test (+10 mm induration or larger), the employee

must have clearance by a chest X-ray prior to initiation of services for the AL Waiver recipients.

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

1. Has had a cough for more than 3 weeks;

2. Has a cough which is productive;

3. Has blood in his sputum;

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

5. Is experiencing night sweats;

6. Is experiencing unexplained weight loss; or

7. Has been in close contact with a person who has active tuberculosis.

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

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

3903.3C RECIPIENT RESPONSIBILITIES

The recipient or the recipient's authorized representative will:

1. Notify the Assisted Living provider and case manager of any change in Medicaid eligibility;

2. Notify the provider and case manager of current insurance information, including the name of the insurance coverage, such as Medicare;

3. Notify the provider and case manager of changes in medical status, service needs, address or location changes, and/or any change in status of legally responsible individual or authorized representative;

4. Treat all staff and providers appropriately;

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

6. Complete, sign and submit all required forms;

7. Not request any provider to perform services not outlined and authorized in the POC; and

8. Furnish the provider with a copy of any existing advance directives.

## 3903.4 DIRECT SERVICE CASE MANAGEMENT

### 3903.4A COVERAGE AND LIMITATIONS

Direct service case management is provided to eligible recipients in the AL Waiver when case management is identified as a service on the POC. The recipient has a choice of direct service case management provided by ADSD staff, an agency or an independent private provider, who are enrolled as Medicaid providers with the QIO-like vendor. These services include:

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

2. Monitoring the overall provision and quality of care of waiver services, in order to protect the health, welfare and safety of the recipient, and to determine that the POC goals are being met;

3. Making certain that the recipient retains freedom of choice in the provision of services;

4. Notifying all affected providers of changes in the recipient's medical status, services' needs, address and location or changes on the status of legally responsible individual or authorized representative;

5. Notifying all affected providers of any unusual occurrence or change in the recipient's health status;

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

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

8. Coordination of multiple service/providers;

9. Case Managers must provide recipients with an appropriate amount of case management services to ensure the recipient is safe and receives sufficient services. Case management is considered an "as needed" service. The case manager is to have monthly contact with each recipient or recipient's authorized representative or legally responsible individual at least 15 minutes per recipient, per month. The amount of case management services billed to the DHCFP must be adequately documented and substantiated by the case manger's notes. This may be a telephone contact;

10. There must be a face to face contact in the place of residence where services are provided to each recipient at least every three months or more often if the recipient has indicated a significant change in his or her health care status or if he or she is concerned about health or safety issues. When a recipient service needs increase due to a temporary condition or circumstance, the case manager must thoroughly document the increased service needs in their case notes. The POC does not need to be revised for temporary conditions or circumstances. A temporary condition or circumstance is defined as an increase or decrease in service needs for a period not to exceed 30 days;

11. During the monthly contact, the case manager assesses the recipient's satisfaction with services and determines if there are any issues with the service provision. The case manager also assesses the need for any changes in services or providers and determines whether the services are promoting the goal(s) stated on the POC, and communicates this information to the ADSD administrative case manager.

3903.4B DIRECT SERVICE CASE MANAGEMENT PROVIDER RESPONSIBILITIES

In addition to all provider responsibilities listed on Section 3903.3B:

1. Providers must meet and maintain the minimum qualifications per the State of Nevada Board of Examiners for Social Workers and the Nevada Board of Nursing for Registered Nurses.

2. Providers must have the ability to conduct home visits. If applicable, Provider Agency must have a business license as required by city, county or state government.

3. Case managers must have one year of experience working with seniors in a home based environment. The case manager does not have to have this experience if the agency supervisor or administrator who supervises the case manager meets these qualifications.

4. Provide evidence to DHCFP of a State/FBI criminal history background check.

5. Conform to HIPAA of 1996 requirements.

3903.4C RECIPIENT RESPONSIBILITIES

1. Each recipient and/or his or her authorized representative must cooperate with the implementation of services and the implementation of the POC.

2. Each recipient is to comply with the rules and regulations of the:

   a. Assisted Living facility;

   b. ADSD;

   c. DWSS;

   d. DHCFP; and

   e. AL Waiver.

3903.5 AUGMENTED PERSONAL CARE SERVICES

3903.5A COVERAGE AND LIMITATIONS

1. Augmented personal care services provided in an AL facility include assistance with the basic self-care and ADLs, homemaker, chore, companion services, medication oversight (to the extent permitted under state law), therapeutic social and recreational programming, and services which will ensure that the residents of the facility are safe, secure, and adequately supervised.

2. The AL facility provides 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.

3. Other individuals or agencies may also furnish care directly, or under arrangement with the assisted living facility, but the care provided by these other entities supplements that provided by the assisted living facility and does not supplant it. The AL facility is the only entity that can enroll as a Medicaid provider and bill for the AL Waiver services.

4. There are three levels of augmented personal care. The level provided is based on the recipient's functional needs to ensure his or her health, safety and welfare in the assisted living facility. Qualified administrative case managers determine the service level and prior authorization for services as an administrative function.

   a. Level One - Provides supervision and cueing to monitor the quality and completion of basic self-care and activities of daily living. Some basic self-care services may require minimal hands-on assistance. This is not a skilled level service, so the ability of the recipient to swallow must be intact. This service level provides laundry services once a week, basic weekly homemaking, assistance with grocery shopping, and community access. This service also provides access to social and recreational programs. This service provides indirect supervision when direct care tasks are not being completed.

   b. Level Two - Provides minimal physical assistance with completion of basic self-care and activities of daily living. Some basic self-care may require a moderate level of assistance. This service level provides laundry services twice a week if needed, daily assistance with homemaking related to self-care, assistance with grocery shopping, and community access. This service provides once daily assistance with in-apartment meal preparation if requested. This service also provides access to and physical assistance with social and recreational programs, and provides indirect supervision with regularly scheduled checks when direct care tasks are not being completed.

   c. Level Three - Provides moderate physical assistance with all basic self-care needs. Some basic self-care may require a maximal level of assistance. This service includes assistance with feeding, if needed. This is not a skilled level service, so the recipient's ability to swallow must be intact. This service level provides laundry service, including changing of linens daily if needed. It includes daily homemaking for clean up after basic self-care tasks and weekly homemaking for general cleaning. This service provides completion of or assistance with grocery shopping and community access. If requested, this service provides up to twice daily assistance with in-apartment meal preparation, access to and physical assistance with social and recreational programs, and direct supervision or safety systems to ensure participant safety when supervision is not direct.

5. Federal Financial Participation (FFP) is unavailable to subsidize the cost of room and board.

3903.5B AUGMENTED PERSONAL CARE SERVICES PROVIDER RESPONSIBILITIES

In addition to provider responsibilities listed in Section 3903.3B:

1. Maintain licensure and standards as outlined by the Health Division, HCQC under NRS 449.037 (Adoption of Standards, Qualifications and other Regulations).

2. Maintain certification from the Department of Business and Industry, Nevada Housing Division.

3. An AL provider may not impose additional fees on the recipient for services covered by Medicaid.

   a. Before authorizing a recipient to move into the facility, the facility must make a full written disclosure to the recipient, regarding what services of personalized care will be available to the recipient and the amount that will be charged for those services throughout the resident's stay at the facility.

   b. The assisted living environment must evidence a setting that provides:

   c. The residents of the facility reside in their own living units which:

      1. contain private toilet facilities;

      2. contain a sleeping area or bedroom;

      3. include a kitchenette; and

      4. are shared with another occupant only upon consent of both occupants.

   d. The facility provides personalized care to the residents of the facility and the general approach to operating the facility incorporates these core principles:

      1. The facility is designed to create a residential environment that actively supports and promotes each resident's quality of life and right to privacy;

      2. The facility is committed to offering high-quality supportive services that are developed by the facility in collaboration with the resident to meet the resident's individual needs;

      3. The facility provides a variety of creative and innovative services that emphasize the particular needs of each individual resident and his personal choice of lifestyle;

4. The operation of the facility and its interaction with its residents supports, to the maximum extent possible, each resident's need for autonomy and the right to make decisions regarding his or her own life;

5. The operation of the facility is designed to foster a social climate that allows the resident to develop and maintain personal relationships with fellow residents and with persons in the general community;

6. The facility is designed to minimize and is operated in a manner which minimizes the need for its residents to move out of the facility as their respective physical and mental conditions change over time; and

7. The facility is operated in such a manner as to foster a culture that provides a high-quality environment for the residents, their families, the staff, any volunteers and the community at large.

e. The assisted living provider must:

1. Notify the case manager within three working days when the recipient states that he or she wishes to leave the facility;

2. Participate with the case manager in discharge planning;

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

4. Notify ADSD of any occurrence pertaining to a waiver recipient that could affect his or her health, safety or welfare;

5. Notify ADSD of any recipient complaints regarding delivery of service or specific Assisted Living facility staff;

6. Provide ADSD with at least a 30-day notice before discharging a recipient unless the recipient's condition deteriorates and warrants immediate discharge;

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

8. Provide care to a newly placed recipient for a minimum of thirty (30) days unless the recipient's condition deteriorates and warrants immediate discharge;

9. Conduct business in such a way that the recipient retains freedom of choice;

10. Comply with rules and regulations for providers as set forth in Medicaid Services Manual Chapter 100;

11. Provide assisted living services to AL Waiver eligible recipients in accordance with the recipient's POC, the rate, program limitations and procedures of the DHCFP;

12. Not use or disclose any information concerning a recipient for any purpose not directly connected with the administration of the AL Waiver except by written consent of the recipient, his or her authorized representative or legally responsible individual;

13. Have sufficient number of caregivers present at the facility to conduct activities and provide care and protective supervision for the residents;

14. Provide at least one caregiver on the premises of the facility if one or more residents are present;

15. Not use Medicaid waiver funds to pay for the recipient's room and board. The recipient's income is to be used to cover room and board costs;

16. Comply with Medicaid regulations in accepting Medicaid payment as payment in full for services rendered, and not contacting the recipient or members of the recipient's family for additional sums related to those services. (MSM Chapter 100);

17. Not bill for services when the recipient is not in the facility or is in suspended status with the AL Waiver ; and

18. Comply with ADSD Assisted Living provider qualifications and standards per Appendix C-1/C-3: "Provider specification for Service" of the approved waiver.

3903.5C RECIPIENT RESPONSIBILITIES

1. Recipients are to cooperate with the AL facility in the delivery of services.

2. Recipients are to report any problems with the delivery of AL services to the AL facility administrator and the case manager.

3903.6 INTAKE PROCEDURES

ADSD has developed procedures to ensure fair and adequate access to the AL Waiver services.

3903.6A COVERAGE AND LIMITATIONS

1. Slot Provision:

a. The allocation of waiver slots is maintained by ADSD Central Office, with sub-lists maintained at each local ADSD office. ADSD determines the number of slots allocated to each local ADSD office.

b. If an AL Waiver recipient voluntarily or involuntary terminates from the waiver and then at a later date wants to reapply for the waiver, the following will be taken into consideration:

1. If the termination took place 90 days or less prior to the request for reinstatement, the recipient will be reinstated on the AL Waiver providing:

a. The request is within the same waiver year.

b. The recipient meets all requirements for waiver eligibility.

2. If the termination took place in a prior waiver year, the following is taken into consideration for reinstatement onto the AL Waiver:

a. Slot availability;

b. Emergent need; and

c. The recipient meets all waiver eligibility requirements.

If the recipient is eligible for reauthorization of waiver services, the administrative case manager will forward all necessary forms to the DHCFP Central Office Waiver Unit for approval. Recipients must cooperate with the reauthorization process.

2. Referral To AL Waiver:

   a. A referral or inquiry for the waiver may be made by a potential applicant or by another party on behalf of the potential applicant by contacting any ADSD office.

   b. If the applicant is not currently a Medicaid recipient, information is provided regarding the Medicaid eligibility process.

   c. Even if the applicant does not appear to meet the functional eligibility criteria for the AL Waiver, he or she must be informed of the right to continue the Medicaid application process through DWSS and, if still deemed ineligible, the right to a fair hearing through DWSS.

3. Wait List:

   a. If the case manager informs ADSD that the applicant appears to meet functional eligibility criteria and no waiver slots are available, the applicant is placed on the AL Waiver Wait List.

   b. At the time of Wait List placement, applicants are notified by ADSD of other options that may be available, such as other HCBW services.

   c. If it has been determined that no slot is expected to be available within the 90 day determination period, ADSD will notify DHCFP Central Office Waiver Unit to deny the application due to no slot available and send out a NOD stating the reason for the denial. The applicant will remain on the waiting list.

4. Waiver Slots Available:

   Once a waiver slot is available, the applicant is allowed the right to choose waiver services in lieu of placement in a nursing facility. If the applicant or authorized representative or legally responsible individual prefers placement in a nursing facility, the case manager will assist the applicant in arranging for nursing facility placement. The applicant has the right to request a hearing if not given a choice between AL Waiver services and nursing facility placement.

5. Effective Date For AL Waiver Services:

   The effective date for AL Waiver service approval is the completion date of all the required forms in the application packet, the Assisted Living facility move-in date, or the Medicaid eligibility date, whichever date is last. If the applicant is in an institution, the effective date cannot be before the date of discharge from the institution.

6. AL Waiver Per Capita Expenditures:

   DHCFP must assure CMS that the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the institutional level of care under the Medicaid State Plan that would have been made in that fiscal year, had the waiver not been granted.

3903.6B DENIAL OF AL WAIVER APPLICATION

Basis of denial for waiver services:

1. The applicant is under the age of 65 years.

2. The applicant does not meet the level of care criteria for nursing facility placement, i.e. the applicant would not require nursing facility placement if AL Waiver services were not available.

3. The applicant has withdrawn his or her request for waiver services.

4. The applicant fails to cooperate with his or her case manager in establishing the POC or verifying eligibility for waiver services.

5. The applicant fails to cooperate with his or her administrative case manager or assisted living service provider in implementing the POC.

6. The case manager, ADSD, DHCFP, or DWSS has lost contact with the applicant.

7. The applicant fails to show a need for AL Waiver services.

8. The applicant has moved out of state.

9. Another agency or program will provide the services.

10. ADSD has filled the number of slots allocated to the AL Waiver. The applicant will be placed on the waiver wait list and will be contacted when a slot is available.

11. There is no Assisted Living facility where the applicant can be placed appropriately and safely. The applicant will be referred to other services.

12. The applicant is in an institution (e.g. hospital, nursing facility, ICF/MR) and discharge within 45 days is not anticipated.

13. The applicant has been placed in an Assisted Living facility that does not have a provider agreement with DHCFP.

14. The applicant chooses to remain at home.

When an application for waiver services is denied, the case manager will send a Notice of Action (NOA) to the DHCFP Central Office Waiver Unit. The DHCFP Central Office Waiver Unit will then send a NOD to the applicant or the applicant's authorized representative or legally responsible individual, via the DHCFP Hearings Unit, informing them that waiver services have been denied and the reason for the denial.

3903.6C SUSPENDED WAIVER SERVICES

1. If it is likely the recipient will be eligible again for waiver services within the next 60 days (for example, if a recipient is admitted to a hospital or nursing facility), a recipient's case is suspended and not closed.

2. An Assisted Living facility is not paid for services on the days that a recipient's case is suspended.

3. If at the end of 45 days the recipient has not been removed from suspended status, the case is closed and the recipient is removed from the waiver.

   When waiver services are suspended, the case manager will send a NOA to the DHCFP Central Office Waiver Unit. The DHCFP Central Office Waiver Unit will then send a NOD to the recipient or the recipient's authorized representative or legally responsible individual, via the DHCFP Hearings Unit, informing them that waiver services have been suspended and the reason for the suspension.

4. Release From Suspended Waiver Services:

   If a recipient has been released from the hospital or nursing facility before 60 days of suspension of waiver services, within five working days, the administrative case manager must:

   a. Complete a new LOC assessment if there has been a significant change in the recipient's condition;

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

   c. Complete a new POC if there has been a change in medical, social or waiver services expected to last longer than 30 days.

d. ADSD will coordinate with the case manager and contact the Assisted Living facility to reestablish services.

3903.6D REDUCTION OF WAIVER SERVICES

A waiver service or services are reduced when:

1. The recipient no longer needs the previously provided level of waiver service(s).

2. The recipient's support system is providing the service(s).

3. The recipient has failed to cooperate with the case manager or the Assisted Living provider in establishing and/or implementing the POC, implementing waiver service(s) or verifying eligibility for waiver service(s).

4. The recipient has requested a reduction in service(s).

5. The recipient's ability to perform activities of daily living has improved.

6. Another agency or program will provide the service(s).

When waiver services are reduced, the case manager will send a NOA to the DHCFP Central Office Waiver Unit. The DHCFP Central Office Waiver Unit will then send a NOD to the recipient or the recipient's authorized representative or legally responsible individual, via the DHCFP Hearings Unit, informing them that waiver services have been reduced and the reason for the service reduction.

3903.6E TERMINATION OF AL WAIVER SERVICES

A recipient will be terminated from the AL Waiver services if:

1. The recipient does not meet the level of care criteria for nursing facility placement;

2. The recipient would not require nursing facility placement if home and community-based services were not available;

3. The recipient has requested termination of waiver services;

4. The recipient fails to cooperate with the case manager or the Assisted Living provider in establishing and/or implementing waiver services;

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

6. The recipient fails to show a need for the AL Waiver services;

7. The recipient has moved out of state;

8. Another agency or program will provide the services;

9. The recipient has been placed in an Assisted Living facility that is not a Medicaid provider;

10. The recipient chooses to return to independent community living;

11. The recipient does not qualify for the AL Waiver services because of institutionalization (e.g. hospital, nursing facility, correctional, ICF/MR), and discharge within 60 days is not anticipated at this time; and

12. The case manager, ADSD, DHCFP or DWSS has lost contact with the recipient.

When waiver services are terminated, the case manager will send a NOA to the DHCFP Central Office Waiver Unit. The DHCFP Central Office Waiver Unit will then send a NOD to the recipient or the recipient's authorized representative or legally responsible individual, via the DHCFP Hearings Unit, informing them that the waiver services have been terminated and the reason for the termination.

When a termination of waiver services is due to the death of a recipient, any agency receiving this information will notify appropriate agencies of the date of death. No NOD is sent.

## 3903.7 BILLING PROCEDURES

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

## 3903.7A COVERAGE AND LIMITATIONS

All providers (Provider Type 59) for the AL Waiver must submit claim forms to DHCFP's Fiscal Agent. Claims must meet the requirements in the CMS 1500 Claim Form. Claims must be complete and accurate. Incomplete or inaccurate claims will be returned to the provider by DHCFP's fiscal agent. If the wrong form is submitted it will also be returned to the provider by DHCFP's fiscal agent.

3903.7B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 3903.3B:

1. Providers must refer to the QIO-like vendor Provider Billing Procedure Manual for detailed instructions for completing the CMS 1500 form.

2. Providers must maintain documentation to support claims billed for a minimum of 6 years from the date of service.

3903.8 ADVANCE DIRECTIVES

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

3903.9 DHCFP ANNUAL REVIEW

DHCFP has in place a formal system in which an annual review of all AL Waiver service providers is conducted, assuring the health and welfare of the individuals served by AL Waiver service providers, the recipient's satisfaction with services, and the cost effectiveness of these services.

The review:

a. Provides CMS annually with information on the impact of the waiver on the type, amount, and cost of services provided under the AL Waiver and the Medicaid State Plan. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of the recipients served on the waiver;

b. Assures financial accountability for funds expended for home and community-based services;

c. Evaluates all provider standards are continuously met, and the POC are reviewed to assure that the services furnished are consistent with the documented needs of the recipients;

d. Evaluates the recipient's satisfaction with the AL Waiver services; and

e. Further assures that all problems identified by the review will be addressed in an appropriate and timely manner, consistent with the severity and nature of any deficiencies.

3903.9A PROVIDER RESPONSIBILITIES

Providers must cooperate with DHCFP's annual review process.

3903.9B RECIPIENT RESPONSIBILITIES

Recipients and/or legally responsible individual must cooperate with DHCFP's annual review process.

# 3904 APPEALS AND HEARINGS

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

## 3904.1 ELDER ABUSE

All members of the ADSD staff, waiver services case managers, and employees of the Assisted Living facility are mandatory reporters of suspected elder abuse. NRS 200.5093 states that anyone "who, in his professional or occupational capacity, knows or has reasonable cause to believe that an older person has been abused, neglected, exploited or isolated…" must report the abuse, exploitation, neglect (including self-neglect) or isolation to the Elder Rights Unit of the ADSD, the local police department or the county's protective services unit in Clark County (if the suspected action occurred in Clark County). This applies to all employees of the ADSD. This report must be made as soon as possible, but no later than 24 hours after the Division employee knows or has reasonable cause to believe that an older person has been abused, neglected, exploited or isolated. NRS 200.5093(1)(b).

a. For the purposes of elder protective services, abuse means willful:

   1. Infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish;

   2. Deprivation of food, shelter, clothing or services which are necessary to maintain the physical or mental health of an older person.

b. Neglect means the failure of:

   1. A person who has assumed legal responsibility or a contractual obligation for caring for an older person, or who has voluntarily assumed responsibility for his or her care, to provide food, shelter, clothing or services which are necessary to maintain the physical or mental health of the older person, or

   2. An older person to provide for his or her own needs because he or she is unable to do so. (NRS 200.5091-200.50995 et seq.)

c. Exploitation means any act taken by a person who has the trust and confidence of an older person or any use of the power of attorney or guardianship of an older person to obtain control, through deception, intimidation or undue influence, over the older person's money, assets, or property with the intention of permanently depriving the older person of the ownership, use, benefit or possession of his or her money, assets or property. As used in this subsection, undue influence does not include the normal influence that one member of a family has over another. (NRS 200.5091-200.50995 et seq.)

d. Isolation means willfully, maliciously and intentionally preventing an older person from having contact with another person by:

1. Intentionally preventing the older person from receiving his or her visitors, mail or telephone calls, including, without limitation, communicating to a person who comes to visit the older person or a person who telephones the older person that the older person is not present or does not want to meet with or talk to the visitor or caller, knowing that the statement is false, contrary to the express wishes of the older person and intended to prevent the older person from having contact with the visitor; or,

2. Physically restraining the older person to prevent the older person from meeting with a person who comes to visit.

The term does not include an act intended to protect the property or physical or mental welfare of the older person or an act performed pursuant to the instructions of a physician who is treating the older person. (NRS 200.5091-200-50995)

It is Division policy that any life-threatening elder abuse must be reported by Division staff to the Elder Rights Unit immediately, either by telephone, in person, or in writing.

Any person making a good faith report of suspected elder abuse is immune from civil or criminal liability for reporting. (NRS 200.5096)

NRS 200.5093 (9) provides that anyone who knowingly and willfully violates the mandatory reporting law is guilty of a misdemeanor.

Recipient safeguards include initiation of investigation by local law enforcement and/or Elder Protective agency, provision of protective services to the older person if they are able and willing to accept them. If the person who is reported to have abused, neglected, exploited or isolated an older person or a vulnerable person is the holder of a license or certificate issued pursuant to chapters 449, 630 to 641B, inclusive, or 654 of NRS, information contained in the report must be submitted to the board that issued the license.

Any employee of the ADSD who knows or should have known that an elderly person is being abused, neglected, exploited or isolated and does not report this to the Elder Rights Unit, Clark County Protective Services (if the suspected action occurred in Clark County), or to law enforcement is subject to disciplinary action, including possible termination. Additionally, the licensing board for any professional employee who fails to report suspected elder abuse would be notified.

The HCQC also receives complaints regarding the facilities they license. ADSD staff receives training regarding the role of the HCQC and how to make appropriate referrals for investigation when events occur that may be considered licensing infractions.