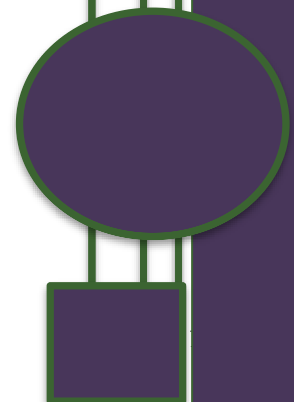
ANNUAL STATEWIDE CONSOLIDATED HCBS FE/PD WAIVER REVIEW FINAL REPORT

FE/PD Waiver Review Period 2022

Home and Community Based Services (HCBS) Waivers for the Frail Elderly (FE) and People with Physical Disabilities (PD) Quality Assurance Consolidated Review to ensure the waiver continues to meet essential Federal statutory assurances and effectively meet the recipient's needs.



State of Nevada
Division of Health Care Financing and Policy
Access & Quality Assurance Unit

October 2023

Review Year: FE (WY 3) & PD (WY 5)

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Annual Statewide Consolidated HCBS FE/PD Waiver Review Final Report

FE/PD Waiver Review Period 2022

Background/Introduction

The renewal of a waiver is contingent on the Centers for Medicare and Medicaid Services (CMS) determining that the State has effectively assured the health, safety, and welfare of waiver recipients during the period the waiver has been in effect.

Each State is expected to have, at a minimum, systems in place to measure and improve performance in meeting the waiver assurances set forth in 42 CFR §441.301 and §441.302. The assurances address important dimensions of waiver quality, including assuring that service plans are designed to meet the needs of waiver recipients and that the State has effective systems in place to monitor recipient health, safety, and welfare.

The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in the waiver application. Through an ongoing process of discovery, remediation, and improvement, the State assures the health, safety, and welfare of the recipients by monitoring: (a) level of care determinations; (b) individuals plans and services delivery; (c) provider qualifications; (d) recipient health, safety, and welfare; (e) financial oversight; and (f) administrative oversight of the waiver.

Aims & Objectives

The annual review monitoring activities provide the foundation for quality improvement by generating information regarding compliance, potential problems, and individual corrective actions. The results can be aggregated and analyzed to measure the overall system performance in meeting the waiver assurances.

Methodology

The CMS quality requirements are founded on an evidence-based approach. The CMS requests evidence from the State that it meets the assurances and applies a continuous quality improvement approach to the assurances. The Division of Health Care Financing and Policy (DHCFP) Quality Assurance (QA) staff uses a representative sample producing a probability of a 95% confidence level with a +/- 5 confidence interval (95/5) to determine the statewide total of recipient files to be reviewed and Participant Experience Surveys (PES) to be completed. A 95/10 representative sample is used for

financial claims reviews. The Annual Statewide Consolidated Review for the Home and Community Based Services (HCBS) waivers for the Frail Elderly (FE) and Persons with Physical Disabilities (PD) for the State of Nevada is conducted monthly. A combined random sample of four hundred thirty-five (435) case files were reviewed, two hundred twelve (212) financial reviews were completed for one hundred thirty-six (136) recipients and one hundred forty-six (146) recipients completed Participant Experience Surveys (PES) for the 2022 waiver year. Due to the limited population of waiver recipients in rural areas, recipients from Elko regional office in this rural area are reviewed bi-annually at one hundred percent (100%).

To avoid duplication of effort, reviews conducted by the Aging and Disability Services Division (ADSD) were obtained for a portion of the case file reviews and the PES for the 2022 review period. All provider reviews were completed by ADSD.

The following areas were evaluated during this year's annual review:

Case File Review:

1. Level of Care (LOC)
2. Comprehensive Social Health Assessment (CSHA)
3. Plan of Care (POC)
4. Statement of Choice (SOC)
5. Acknowledgement Form
6. Forms
7. Monthly Contacts and Documentation

Financial Review:

1. Eligibility
2. Prior Authorization
3. Daily Records
4. Payment

Participant Experience Surveys (PES)

1. Access to Care
2. Choice and Control
3. Respect/Dignity
4. Community Integration/Inclusion

Listed below are the specific HCBS FE/PD waivers, the Medicaid Services Manual (MSM) Chapters and Policy & Procedure (P&P) Transmittals that were used in the implementation of this annual review:

- 1915(c) Home and Community Based Services Waiver for the Frail Elderly (Effective 12/01/2020 and 04/01/2023)
- 1915(c) Home and Community Based Services Waiver for Persons with Physical Disabilities (Effective 12/01/2020 and 01/01/2023)
- MSM Chapter 2200 Home and Community Based Waiver for the Frail Elderly (Effective 02/01/2021 and 07/01/2022)
- MSM Chapter 2300 Home and Community Based Waiver for Persons with Physical Disabilities (Effective 09/25/2019 and 07/01/2022)
- P&P FE-PD-21-001 - Direct Case Management ongoing contacts
- P&P FE-PD-21-002 - Annual Plan of Care Updates and Changes
- Appendix K: Emergency Preparedness and Response COVID-19 Addendum (Issued 01/19/2021 and 03/01/2022)

The following results identify the areas and percentages of compliance with performance measures which are required from the approved waivers and requirements outlined in the above documents.

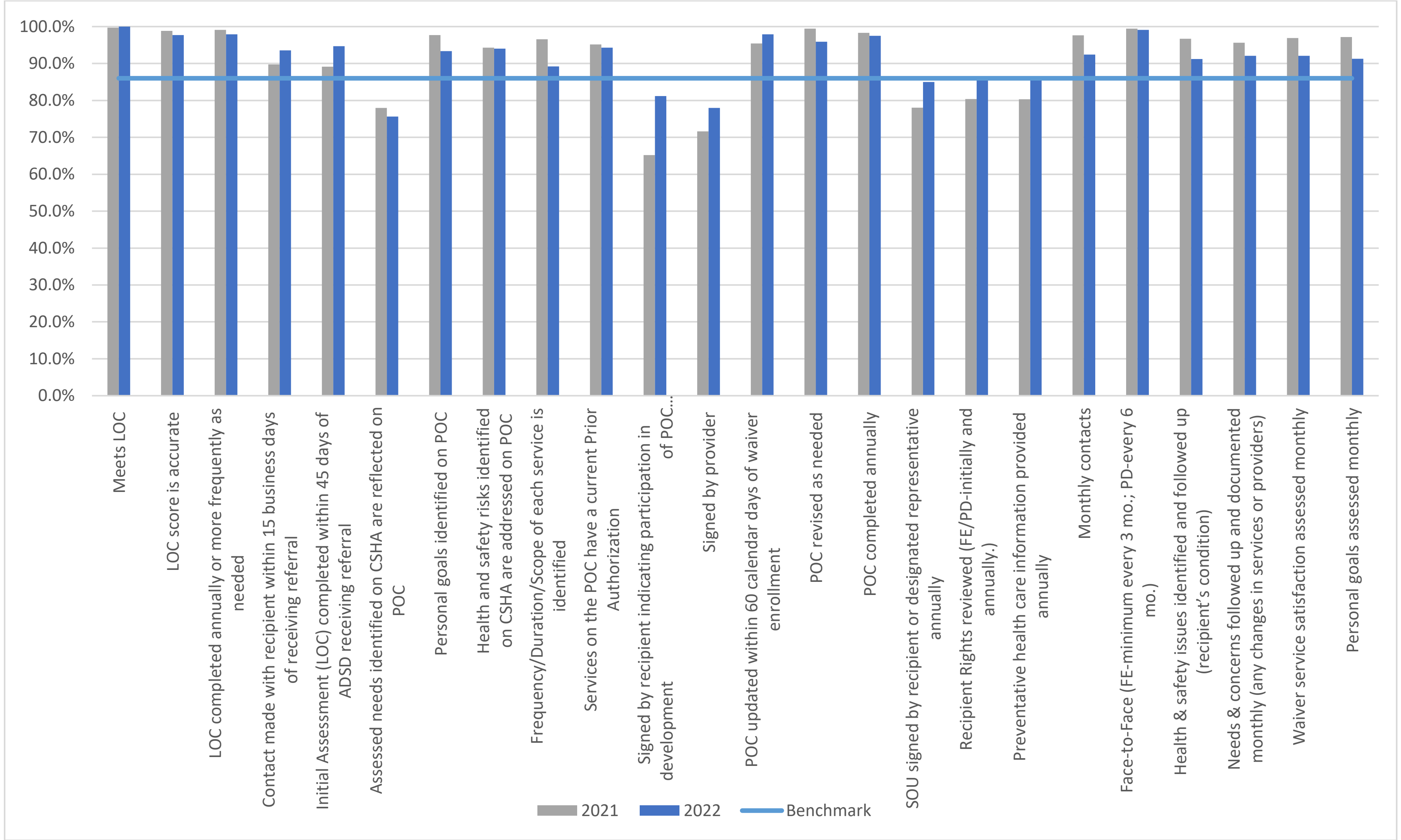
Results

2022 Statewide Case File Results

	LOC/CSHA					Plan of Care										Forms			Monthly Contacts and Documentation					
	Meets LOC (at least 3 functional deficits) (New enrollees ONLY)	Meets LOC and LOC score completed accurately (Ongoing ONLY)	LOC completed annually or more frequently as needed	Contact made with recipient within 15 business days of receiving referra (New enrollees ONLY)	Initial Assessment (LOC) completed within 45 days of ADSD receiving referral (New enrollees ONLY)	Assessed needs identified on (C)SHA are reflected on POC	Personal goals identified on POC	Health and safety risks identified on CSHA are addressed on POC	Frequency/Duration/Scope/Amount of each service is identified	Services on the POC have a current Prior Authorization	Signed by recipient indicating participation in development of POC (within 60 days)	Signed by provider (within 60 days)	POC updated within 60 calendar days of waiver enrollment (New enrollees ONLY)	POC revised as needed (when a significant change lasting more than 30 days occurs)	POC completed annually	SOC signed by recipient or designated representative annually	Recipient Rights reviewed (FE/PD-initially and annually)	Preventative health care information provided annually	Person Centered Contact	Face-to-Face	Health & safety issues identified and followed up (recipient's condition)	Needs & concerns followed up and documented (any changes in service or providers)	Waiver service satisfaction assessed	Personal goals assessed
YTD COMPLIANCE %	100.0%	97.7%	97.9%	93.6%	94.7%	75.6%	93.3%	94.0%	89.2%	94.3%	81.2%	78.0%	97.9%	95.9%	97.5%	85.0%	86.1%	85.8%	92.4%	99.1%	91.2%	92.1%	92.1%	91.3%

Note: The above review elements below the 86% threshold are highlighted in yellow.

Case File Comparison



2021 vs 2022 Case File Review Comparison

For 2022, improvement is noted for eight (8) components from the previous 2021 review period. The top three (3) areas of improvement include: "Signed by recipient indicating participation in development of POC" at eighty-one percent (81%), increasing sixteen percent (16%) from the last year, "SOC signed by recipient" at eighty-five percent (85%) increasing seven percent (7%) from previous year, "Signed by provider", at seventy-eight (78%) increasing over six percent (6%) from the previous year.

Nineteen (19) review elements are at or above the eighty-sixth percentile (86%) with fifteen (15) elements remaining above ninety percent (90%) and two (2) increasing into the ninetieth percentile (90%) for compliance.

One (1) element previously under eighty-sixth percentile (86%), "Recipient rights reviewed", has now come into compliance.

Findings and Recommendations

Findings identify areas of deficiency discovered through the completion of the Annual Statewide HCBS FE/PD Waiver Review. Recommendations are suggestions to help improve the effectiveness and quality of waiver operations. The following findings and recommendations are provided as guidance to develop best practices for continuing quality improvement:

Case File Review Results

ADSD Offices

CMS requires quality improvement projects/remediation when the threshold of compliance is below eighty-six percent (86%). For the 2022 review period, five (5) elements have been identified as needing further analysis by the Quality Improvement (QI) committee.

- Assessed needs identified on CSHA are reflected on POC: 75.6%
- POC signed by recipient within 60 days: 81.2%
- POC signed by provider within 60 days: 78.0%
- SOC signed by recipient or designated representative: 85.0%
- Preventative health care information provided: 85.8%

The following findings and recommendations are provided as guidance to develop best practices for continuing quality improvement:

- **Assessed needs identified on CSHA are reflected on POC**: Twenty-four percent (24%) of the files reviewed either had items identified on the CSHA that were not on the POC, or vice versa, identified on the POC that were not on the CSHA without documentation.

Recommendation: This review period saw a decrease of just over two percent (2%) in compliance. DHCFP QA held consistency meetings with DHCFP Long Term Services and Supports (LTSS) and ADSD to review the CSHA and POC comparisons. ADSD stated they had been working on getting a new process for an offline CSHA that would auto-populate an offline POC which should decrease the matching errors. The ADSD templates have been approved by both the administrative and operations agencies. The implementation of these templates should increase compliance for the new waiver year.

- **POC signed by recipient within sixty (60) days:** Eighteen percent (18%) of the POCs reviewed were either not signed or not signed within the required timeframe by the recipient or their designated representative.

  Recommendation: This review period saw an increase of sixteen percent (16%) in compliance for this element due to the ending of the COVID-19 pandemic and the ability to resume face-to-face contacts to obtain timely signatures. The case managers will continue to work to reduce errors within this element by creating handwritten initial and updated POCs that can be signed and dated at the face-to-face meetings.

- **POC signed by provider within sixty (60) days:** Twenty-two percent (22%) of the POCs reviewed were either not signed or not signed within the required timeframe by the provider or case manager.

  Recommendation: The review period showed an increase of just over six percent (6%) in compliance for this element. With the pandemic ending, case managers stated that providers have more time to sign documents. Staff training is ongoing to verify signatures are being obtained in a timely manner.

- **SOC signed by recipient or designated representative:** Fifteen percent (15%) of the SOCs reviewed were either not signed or not signed annually/timely.

  Recommendation: This review period saw an increase of seven percent (7%) in compliance for this element. This increase was partially due to the ending of the COVID-19 pandemic. Meeting face-to-face is returning to instead of virtual meetings so signatures are easier to obtain.

- **Preventative health care information provided:** Fourteen percent (14%) of the Acknowledgement Forms (NMO-7075) reviewed were either not initialed/signed or not initialed/signed annually.

  Recommendation: The review period showed an increase of almost six percent (6%) in compliance for this element. This increase was partially due to the ending of the COVID-19 pandemic. Meeting face-to-face is returning to instead of virtual meetings so signatures are easier to obtain.

Additional Recommendations

- ADSD and DHCFP QA continue to have challenges when it comes to completing case file reviews consistently. DHCFP QA has reviewed how they complete a case file review, noting policy for each question and which should have percentages with ADSD during Quality Improvement and Consistency meetings. DHCFP QA will continue to discuss review questions as needed to help ensure consistency.

- ADSD to ensure all documentation for the rolling year is reviewed for the internal case files reviews.

- ADSD case management provider to ensure they are sending required documentation for DHCFP QA to complete case file reviews.

DHCFP LTSS, DHCFP QA and ADSD (both operations and the case management side) worked together to review policy to ensure all items reviewed are in accordance with regulations.

Progress will be monitored in the Quality Improvement Operations quarterly meetings.

Best Practices

Best practices are methods or techniques that represent the most efficient or prudent course of action. The following practices were observed contributing to the quality of health, safety, and welfare of waiver recipients:

- ADSD case management supervisors provide continual guidance to staff regarding clear documentation during contacts and assessments.
- Clear contact notes make it easier to follow the recipient's progress and demonstrate the efforts the case manager makes to respond to the recipient's needs.
- ADSD case management has been building a rapport with waiver and non-waiver providers to assist with building a cohesive person-centered plan for recipients.

- The Electronic Visit Verification (EVV) system is being used to obtain recipient and provider signatures for verification of services which has increased compliance.

- Staff training for newly hired case managers and refresher training are being held to review processes and policy changes.

- ADSD recently separated their operations and providers into two (2) separate units to eliminate any potential conflict of interest.

- ADSD operations has created an offline CSHA that auto-populates to an offline POC which should decrease the errors of the two not matching.

Quality Improvement Project Performance

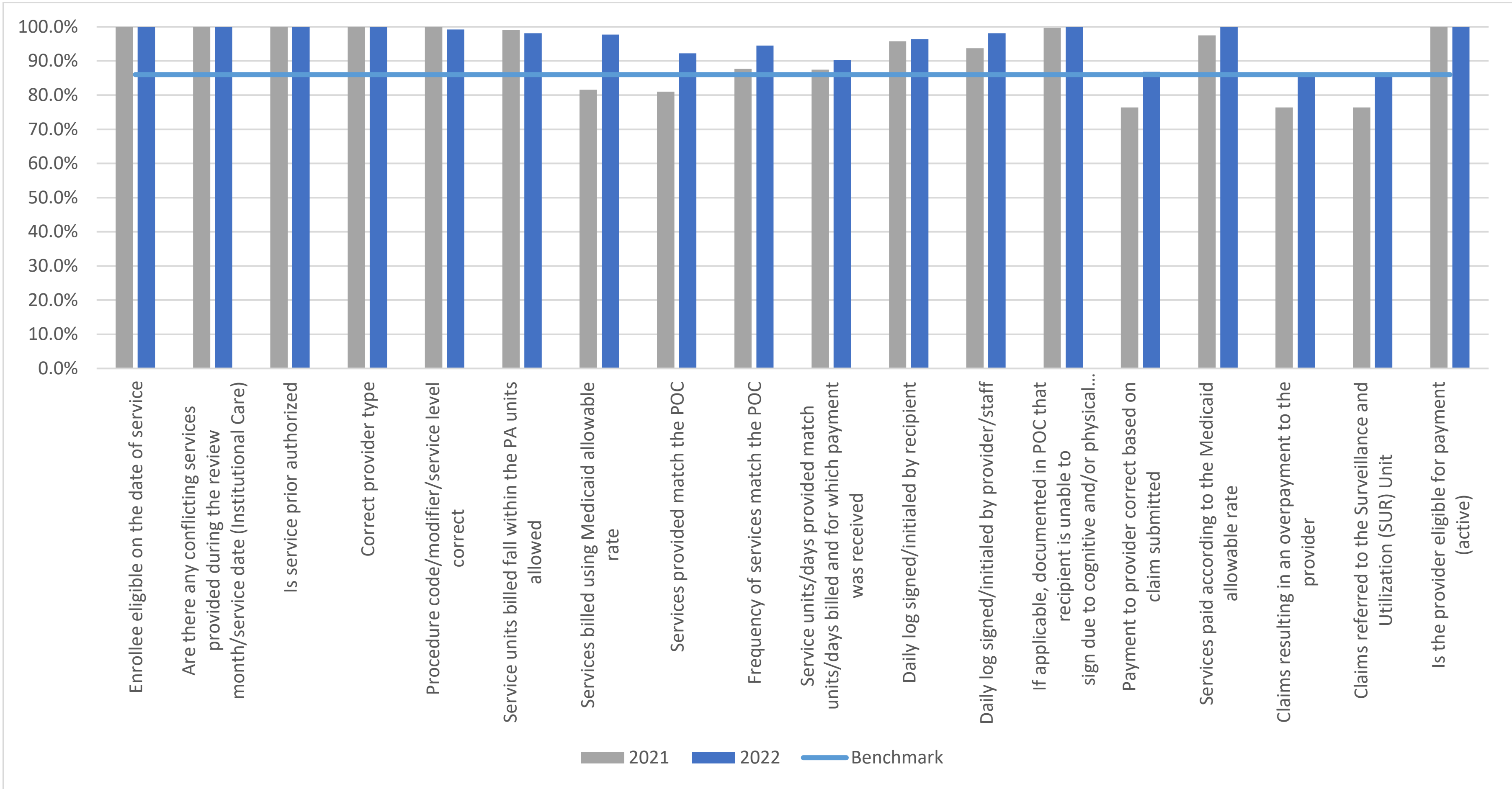
As part of the consolidated review process, DHCFP LTSS, DHCFP QA and ADSD gather monthly for a Consolidated Waiver Quality Improvement (QI) Committee meeting. DHCFP LTSS, DHCFP QA and ADSD operations meet quarterly to review areas that are below the threshold. CMS has mandated a threshold of less than eighty-six percent (86%) for any Performance Measure indicating a need for improvement to address.

Assurances that are below eighty-six percent (86%) for the review period are assigned to a priority grid. The Quality Improvement (QI) Committee members are assigned projects to analyze and identify the probable cause of deficiencies and develop plans to improve performance and track improvement.

The QI Committee is responsible for conducting the QI Projects for the Consolidated Waiver Review as issues are identified, as well as at the time of the final Consolidated Annual Waiver Review Report. The committee will conduct all QI Projects related to the waiver reviews using the following the CMS guidance:

- ➢ Identify probable challenges to meeting compliance.
- ➢ Develop interventions designed to improve performance.
- ➢ Allow enough time for intervention to have an effect.
- ➢ Measure impact (performance increase, decrease, unchanged).

Financial Review Comparison



2021 vs 2022 Financial Review Comparison

For 2022, improvement is noted in nine (9) components from the previous 2021 review period to the current 2022 review period. The most notable being in: "Services billed using Medicaid allowable rate" at almost ninety-eight percent (98%) seeing an increase of over sixteen percent (16%) from the prior reporting year, "Services provided match the POC" at over ninety-two percent (92%) showing an increase of over eleven percent (11%), as well as "Payments to provider correct based on claim submitted" at almost eighty-seven percent (87%) increasing of over ten percent (10%) from the previous year. Additionally, six (6) review elements remained at one hundred percent (100%) compliance with one (1) additional element "Services paid according to Medicaid allowable rate" coming into one hundred percent (100%) compliance.

Financial Review Results

Elements with no change since last review period:

- Enrollee eligible on the date of service
- Are there any conflicting services provided
- Is service prior authorized
- Correct provider type
- Documented recipient unable to sign
- Is the provider eligible for payment (active)

***The following elements showed a compliance increase from the previous review period*:**

- Services billed using Medicaid allowable rate: 16%
- Services provided match the POC: 11%
- Frequency of services match the POC: 7%
- Service units/days provided match units/days billed: 2%
- Daily log signed by provider: 4%
- Payment to provider correct based on claim submitted: 11%
- Services paid according to the Medicaid allowable rate: 2%

Financial review results reflect compliance for the provider community. No review elements are currently under compliance thresholds.

Recommendations: To maintain continued compliance and ensure elements remain above thresholds, providers need to continue to ensure all requested verifications are provided, including the days billed match the days services were rendered.

LTSS Waiver Unit

DHCFP Central Office- LTSS Waiver Unit

The 1915(c) HCBS Waiver for Persons with Physical Disabilities was renewed effective date of 01/01/2023 and the 1915(c) HCBS Waiver for the Frail Elderly was renewed effective date of 04/01/2023.

MSM Chapters 2200 and 2300 were both updated and approved to be effective 07/01/2022.

Participant Experience Surveys (PES)

The focus of the HCBS Waiver Programs is to ensure the recipient is satisfied with their services and achievement of desired outcomes. Recipients were interviewed regarding their experiences and satisfaction with their waiver services and providers. The interviews were conducted by the DHCFP QA staff and the ADSD staff using the Participant Experience Survey (PES) interview tool developed by The MedStat Group, Inc. under a contract from the CMS. Indicators used for monitoring quality within the waiver programs are calculated using the data captured from these surveys.

The HCBS FE and PD Waiver recipients who were randomly selected for case file reviews were asked to participate in the annual PES interviews for Carson City, Las Vegas, Elko and Reno. PES interviews were conducted by ADSD monthly and on a biannual basis by DHCFP QA. PES interviews included within this report cover July 2022 through June 2023. Four hundred thirty-five (435) recipients were selected to meet a 95/5 sample size. DHCFP QA staff completed PES interviews via telephone and advised recipients they could be completed and mailed back on their own if they chose to do so. Of the four hundred thirty-five (435) possible surveys, one hundred sixty-two (162) PES interviews were completed for a thirty-seven percent (37%) completion rate. Twenty-seven (27) recipients chose not to complete the survey for a six percent (6%) refusal rate. One-hundred thirteen (113) cases were no longer receiving services due to the recipient moving or the recipient passing away for twenty-six percent (26%). One hundred thirty-three (133) were not completed as recipients were unable to be reached after three (3) attempted phone calls or invalid phone numbers for thirty-one percent (31%), totaling fifty-seven percent (57%) rate of unable to complete rate.

As compared to the 2021 review period, for 2022 the percentages for overall satisfaction with services, ability to contact case manager and access to care (obtaining groceries and laundry services) increased. Choice of staff, careful listening by home staff and access to care (staff time) satisfaction decreased from 2021 compared to 2022. Survey elements that remained stable from 2021 to 2022 were access to equipment and modifications, respect by home care staff, and community involvement.

Recipient issues determined to be critical and in need of immediate attention were promptly communicated to the appropriate ADSD office staff.

The top areas with the highest recipient satisfaction were:

- ✓ Staff Time
- ✓ Case Manager Helpfulness
- ✓ Overall Satisfaction with Case Manager and Services
- ✓ POC Development
- ✓ Respect by Home Care Staff, Day Program Staff, and Transportation Staff
- ✓ Careful Listening by Home Care Staff, Day Program Staff, and Transportation Staff
- ✓ Access to Care Regarding Eating, Meal Prep, and Medication
- ✓ Community Involvement

The areas with the highest adverse responses indicating an unmet need were:

- ✓ Access to Care Regarding Bathing, Housework, and Equipment/Modifications
- ✓ Choice in Staff
- ✓ Directing Staff

The DHCFP QA staff understands that due to the nature of the population interviewed, inconsistencies or circumstantial answers were noted in responses from the HCBS FE/PD waiver recipients. The State has experienced staffing shortages in many of the provider fields which does impact the choice of staff and unmet need responses. Positive feedback was noted from recipients and designated representatives expressing satisfaction with their providers, including case managers.

Requirements[1]

Case File Review Requirements				
Level of Care (LOC)/Comprehensive Social Health Assessment (CSHA)				
Assurance	**Waiver Requirement**	**Waivers**	**MSM Requirement**	**MSM Chapter**
Meets LOC (at least three functional deficits)	FE The assessment determines if the condition requires the level of services offered in a nursing facility with at least 3 functional deficits identified in sections 1-5 of the screening tool or a more integrated service which may be community based. PD There are 13 total functional deficits identified on the LOC Assessment Tool. An eligible recipient or pending applicant must meet at least three deficits out of the 13 possible.	FE Appendix B: Participant Access and Eligibility, Section B-6: Evaluation/Reevaluation of Level of Care, (d) PD Appendix B: Participant Access and Eligibility, Section B-6: Evaluation/Reevaluation of Level of Care, (d)	FE Each applicant /recipient must meet and maintain a level of care for admission into a nursing facility and would require imminent placement in a nursing facility (within 30 days or less) if HCBW services or other supports were not available. Effective 02/01/2021 FE Each applicant /recipient must meet and maintain a Level of Care (LOC) for admission into a nursing facility and would require imminent placement in a NF (within 30 days or less) if HCBS services or other supports were not available PD The applicant must meet and maintain a LOC for admission into a nursing facility within 30 calendar days if HCBW services or other supports were not available.	FE MSM Chapter 2200, Section 2203.2A(5)(a)(1)(b) Effective 02/01/2021 FE MSM Chapter 2200, Section 2203.1(A)(2) PD MSM Chapter 2300, Section 2303.2A(2)(b)
LOC score is accurate	FE/PD Performance Measure: Number and percent of recipients whose LOC eligibility was based on accurate application of policy resulting in accurate LOC determinations.	FE/PD Appendix B: Evaluation/Revaluation of Level of Care. Quality Improvement: Level of Care, (a)(i)(c)	N/A	N/A

LOC completed annually or more frequently as needed	FE/PD Clients must be assessed at minimum annually while receiving waiver services to reaffirm eligibility, including level of care. If there is a significant change in the client's condition that would affect the level of services or program eligibility, reassessment is made at that time. FE Re-evaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule: every 12 months.	FE/PD Appendix B: Participant Access and Eligibility, Section B-6: Evaluation/Reevaluation of Level of Care, (g)	The recipient's LOC and SHA must be reassessed at a minimum annually. The recipient's LOC, functional status and needs addressed by the POC must be reassessed annually or more often as needed.	FE MSM Chapter 2200, Section 2203.1A(3)(b) Effective 02/01/2021 FE MSM Chapter 2200, Section 2203.11A(3)(b) PD MSM Chapter 2300, Section 2303.1A(3)(b) FE MSM Chapter 2200, 2203.4A(5)(a) Effective 07/01/2023 PD MSM Chapter 2300, 2303.4A(5)(a) FE MSM Chapter 2200, 2203.12A(3)(b) Effective 07/01/2022 PD MSM Chapter 2300, 2303.1A(3)(b)
Contact made with recipient within 15 working days of receiving referral (**New enrollees ONLY**)	FE/PD When a referral is received and assigned; the Intake Specialist makes phone/verbal contact with the applicant or his or her representative within fifteen working days of receipt of the referral.	FE/PD Appendix B: Participant Access and Eligibility, Section B-6: Evaluation/Reevaluation of Level of Care, (f)	FE ADSD will make phone/verbal contact with applicant/representative within fifteen working days of the referral date. Effective 02/01/2021 FE The ADSD intake specialist will make phone/verbal contact with the applicant/ designated representative/LRI within 15 working days from the referral date.	FE MSM Chapter 2200, Section 2203.13A(1)(b) Effective 02/01/2021 FE MSM Chapter 2200, Section 2203.12A (1)(b)
Initial assessment LOC completed within 45 calendar days of ADSD receiving referral (**New enrollees ONLY**)	FE The face-to-face assessment to determine the level of care and waiver service need must occur within 45 calendar days of the referral date to assure timely access to services. PD Within 45 calendar days of the referral a face-to-face visit is made to assess the LOC, complete forms and gather the medical records.	FE/PD Appendix B: Participant Access and Eligibility, Section B-6: Evaluation/Reevaluation of Level of Care, (f)	Effective 02/01/2021 FE If the applicant appears to be eligible, a face-to-face visit must be scheduled/completed within 45 calendar days from the referral date to assess eligibility including NF LOC determination.	Effective 02/01/2021 FE MSM Chapter 2200, Section 2203.12A(1)(c)
Plan of Care (POC)				
Assurance	**Waiver Requirement**	**Waivers**	**MSM Requirement**	**MSM Chapter**
Assessed needs identified on CSHA are reflected on POC	FE/PD Performance Measure: Number and percent of recipients POCs that address the assessed needs	FE/PD Appendix D: Participant-Centered Planning and Service Delivery, Section Quality	FE/PD The POC must reflect the recipient's service needs and include both waiver and non-waiver services in place at	FE MSM Chapter 2200, Section 2203.1A(3)(a) PD MSM Chapter 2300, Section 2303.1A(3)(a)

	identified in the social health assessment.	Improvement: Service Plan, (a)(i)(a)	the time of POC completion, along with informal support that is necessary to address those needs. Effective 02/01/2021 FE Development of the POC identifying the waiver services as well as other ongoing community support services that the recipient needs to live successfully in the community. 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.	Effective 02/01/2021 FE MSM Chapter 2200, Section 2203.11A(3)(b) FE MSM Chapter 2200, 2203.12A(3)(b) Effective 07/01/2022 PD MSM Chapter 2300, 2303.1A(3)(a)
Personal goals identified on CSHA are addressed on POC	FE/PD Number and percent of recipients POCs that address personal goals identified in the social health assessment. FE Performance Measure: Number and percent of recipients POC's that include personalized goals.	FE/PD Appendix D: Participant-Centered Planning and Service Delivery, Section Quality Improvement: Service Plan, (a)(i)(a)	FE/PD Monitoring the overall provision of waiver services, to protect the safety and health of the recipient and to determine that the POC goals are being met. Effective 02/01/2021 FE "… POC personalized goals are being met"	FE MSM Chapter 2200, Section 2203.4A(3) PD MSM Chapter 2300, Section 2303.3E(3) Effective 02/01/2021 FE MSM Chapter 2200, Section 2203.3A(3)
Health and safety risks identified on CSHA are addressed on POC	FE/PD Performance Measure: Number and percent of recipients POCs that address health and safety risk factors identified in the social health assessment.	FE/PD Appendix D: Participant-Centered Planning and Service Delivery, Section Quality improvement: Service Plan, (a)(i)(a)	FE Monitoring the overall provision and quality of care of waiver services, to protect the health, welfare and safety of the recipient, and to determine that the POC goals are being met. PD A written POC is developed in conjunction with the recipient by the DHCFP District Office Case Manager for each recipient under the waiver. The POC is based on the assessment of the recipient's health and welfare needs.	FE MSM Chapter 2200, Section 2203.4A(3) Effective 02/01/2021 FE MSM Chapter 2200, Section 2203.3A(3) PD MSM Chapter 2300, Section 2303.14A(4)(a)(5)(a)

Frequency/Duration/Scope of each service is identified	FE/PD Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.	FE/PD Appendix D: Participant-Centered Planning and Service Delivery, Section Quality improvement: Service Plan, (a)(i)(d)	FE 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. PD N/A The recipient is afforded a choice of service and providers, establishing the frequency, duration and scope. Each provider must have a file for each recipient. In 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.	FE MSM Chapter 2200, Section 2203.3B(1)(h) Effective 02/01/2021 FE MSM Chapter 2200, Section 2203.10B(3)(a) PD N/A Effective 07/01/2023 FE MSM Chapter 2200, 2203.4A(3)(b) PD MSM Chapter 2300, 2303.4A(3)(b) Effective 07/01/2022 FE MSM Chapter 2200, 2203.11B(3)(a) PD N/A
Services on the POC have a current prior authorization	FE/PD The case manager ensures that the services on the POC are assigned the appropriate prior authorization. PD All waiver services are prior authorized.	FE/PD Appendix D: Participant-Centered Planning and Service Delivery, Section Quality Improvement: Service Plan, (b)(i) PD Appendix I: Financial Accountability Section I-2: Rates, Billing and Claims (1) (b)(2)	FE Ensure completion of prior authorization form, if required, for all waiver services documented on the POC for submission into the Medicaid Management Information System (MMIS). PD Preliminary and ongoing assessments, evaluations and completion of forms required for service eligibility: 11. Completion of prior authorization form in the Medicaid Management Information System (MMIS).	FE MSM Chapter 2200, Section 2203.1A(10) Effective 02/01/2021 FE MSM Chapter 2200, Section 2203.11A(10) PD MSM Chapter 2300, Section 2303.1A(11)
Signed by recipient indicating participation in development of POC (within 60 calendar days of SOC date/waiver date/prior POC)	PD Performance Measure: Number and percent of recipients POCs that contain the recipient's signature indicating participation in POC development. FE/PD The plan is completed no more than 60 calendar days from waiver enrollment. The finalized service plan must be signed and dated by both the recipient and providers.	PD Appendix D: Participant-Centered Planning and Service Delivery, Section Quality Improvement: Service Plan, (a)(i)(b) FE/PD Appendix D: Participant-Centered Planning/Service Delivery, D-1: Service Plan Development (d)(a)	FE If services documented on a POC are approved by the recipient and the case manager and the recipient signature cannot be obtained due to extenuating circumstances, services can commence with verbal approval from the recipient. Case managers must document the recipient's verbal approval in the case notes and obtain the recipient signature on the POC as soon as possible. FE All forms must be completed with initials,	FE MSM Chapter 2200, Section 2203.1A(3)(c) Effective 02/01/2021 FE MSM Chapter 2200, Section 2203.12A(5)(d) PD MSM Chapter 2300, Section 2303.14A(4)(a)(6)

			signatures, and dates by the recipient/designated representative/LRI. Electronic signatures are acceptable pursuant to NRS 179 "Electronic Records and Transactions" on forms that require a signature. PD All forms must be complete with signature and dates when required.	
Signed by provider (within 60 days calendar of SOC date/waiver date/prior POC)	FE/PD The plan is completed no more than 60 calendar days from waiver enrollment. The finalized service plan must be signed and dated by both the recipient and providers.	FE/PD Appendix D: Participant-Centered Planning and Service Delivery, D-1: Service Plan Development (d)(a)	N/A	N/A
POC updated with waiver enrollment (**New enrollees ONLY**)	FE Performance Measure: Number and percent of new applicants whose POC is completed within no more than 30 calendar days of waiver enrollment. PD Performance Measure: Number and percent of new applicants whose POC is completed within no more than 60 calendar days of waiver enrollment. FE/PD The POC is completed no more than 60 calendar days from wavier enrollment.	FE Appendix D: Participant-Centered Planning and Service Delivery, Section Quality Improvement: Service Plan, (a)(i)(b) PD Appendix D: Participant-Centered Planning and Service Delivery, Section Quality Improvement: Service Plan, (a)(i)(b) FE/PD Appendix D: Participant-Centered Planning and Service Delivery Section D-1: Service Plan Development (d)(a)	N/A	N/A
POC revised as needed (when a significant change lasting more than 30 days occurs)	FE/PD Performance Measure: Number and percent of recipients' POCs that are updated when the recipient's needs changed. **Information above is also still present. FE Ongoing POC's are updated and revised when there is a significant change expected to last more than 30 days that occurs outside the annual review.	FE/PD Appendix D: Participant Centered Planning and Service Delivery, Section Quality Improvement: Service Plan, (a)(i)(c) FE/PD Appendix D: Participant-Centered Planning and Service Delivery, Section D-1: Service Plan Development, (4)(d)(a)	FE The recipient's level of care, functional status and needs addressed by the POC must be reassessed annually or more often as needed. PD The recipient's LOC, functional status and needs addressed by the POC must be reassessed annually or more often as needed.	FE MSM Chapter 2200, Section 2203.1A(3)(b) PD MSM Chapter 2300, Section 2303.1A(3)(b) Effective 02/01/2021 FE MSM Chapter 2200, Section 2203.11A(3)(b)

	PD The POC is revised annually, or when a significant change occurs that lasts greater than 30 days.			
POC completed annually	FE/PD Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.	FE/PD Appendix D: Participant Centered Planning and Service Delivery, Section Quality Improvement: Service Plan, (a)(i)(c)	N/A	N/A
Forms				
Assurance	**Waiver Requirement**	**Waivers**	**MSM Requirement**	**MSM Chapter**
SOC signed by recipient or authorized representative	FE Performance Measure: Number and percent of recipients whose SOC is signed indicating choice [of] providers and choice of services. PD Performance Measure: Number and percent of recipients whose SOC is signed indicating choice of waiver services and institutional care, choice of providers and choice of services.	FE Appendix D: Participant-Centered Planning and Service Delivery, Section Quality Improvement: Service Plan, (a)(i)(e) PD Appendix D: Participant-Centered Planning and Service Delivery, Section Quality Improvement: Service Plan, (a)(i)(e)	FE ADSD will forward an initial assessment (IA) packet to the DHCFP Central Office Waiver Unit, which will include: ... the Statement of Understanding/Choice (SOC) must be complete with signature and dates. Effective 02/01/2021 FE The Statement of Understanding/Choice (SOC) must be complete with signature and dates. PD The recipient or the recipient's authorized representative will: …complete, sign and submit all required forms.	FE MSM Chapter 2200, Section 2203.13A(3)(a)(6)(d) Effective 02/01/2021 FE MSM Chapter 2200, Section 2203.12A(5)(b) PD MSM Chapter 2300, Section 2303.3C(14)
Recipient Rights reviewed (initially and annually)	FE The client Bill of Rights is reviewed during the initial application process and as needed thereafter. FE Annually-Recipient Rights form is reviewed with and provided to the participant/guardian/family during the personal assessment and reassessment. PD Case managers provide a copy of the HCBS Recipient Rights to all individuals at the initial home visit and annual home visit so. In addition, case managers review the Recipient Rights at the six-month home visit.	FE Appendix G: Participant Safeguards, Appendix G-1: Response to Critical Events or Incidents c. Participant Training and Education PD Appendix B: Evaluation/Revaluation of Level of Care, Section Quality Improvement: Level of Care, (a)(i)(c)(ii)	FE All required forms must be complete with signature and dates where required. Effective 02/01/2021 FE 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 PD The recipient or the recipient's authorized representative will: ... sign all required forms.	FE MSM Chapter 2200, Section 2203.13A(3)(a)(9) Effective 02/01/2021 FE MSM Chapter 2200, Section 2205 PD MSM Chapter 2300, Section 2303.3C(14)

Preventative health care information provided annually	FE/PD Performance Measure: d) Number and percent of recipients who receive information annually regarding preventative health care.	FE/PD Appendix G: Participant Safeguards, Quality Improvement: Health and Welfare, (a)(i)(a)(d)	N/A	N/A
Monthly Contacts and Documentation				
Assurance	**Waiver Requirement**	**Waivers**	**MSM Requirement**	**MSM Chapter**
Contact with each recipient completed monthly Face-to-Face (minimum annually) (Appendix K)	FE Contacts may be by telephone, but there must be a home visit to each recipient at least every three months, or more often if the recipient has indicated a significant change in status or if there are reasons for concern about health and safety. PD The direct service case manager must have a monthly contact with each waiver recipient and/or the recipient's authorized representative, this may be a telephone contact. At a minimum, there must be a face-to-face visit with each recipient once every six months. More contacts may be made if the recipient has indicated a significant change in his or her health care status or is concerned about his or her health and/or safety.	FE Appendix D: Participant-Centered Planning and Service Delivery, Section D-1: Service Plan Development (4)(d)(f) PD Appendix D: Participant-Centered Planning and Service Delivery, Section D-1: Service Plan Development (4)(d)(f)	FE The case manager must have a monthly contact with each waiver recipient and/or the recipient's authorized representative; this may be a telephone contact. At a minimum, there must be a face-to-face visit with each recipient once every three months…During the monthly contact, the case manager monitors and documents the quality of care of the recipient. Quality of care includes the identification, remediation and follow-up of health and safety issues, needs and concerns of the recipient, waiver service satisfaction and whether the services are promoting goals stated in the POC. Effective 02/01/2021 FE The case manager must have ongoing contact with each waiver recipient and/or the recipient's designated representative/LRI; this may be a telephone contact. At a minimum, there must be one face-to-face visit with each recipient annually. All other ongoing contacts may be by telephone, fax, e-mail, or face-to-face. PD The direct service case manager must have a monthly contact with each waiver recipient and/or the recipient's authorized representative; this may be a telephone contact. At a minimum, there must be a face-to-face visit with each recipient once every six (6) months.	FE MSM Chapter 2200, Section 2203.4A(4)(a)(c) Effective 02/01/2021 FE MSM Chapter 2200, Section 2203.3A(4)(a) PD MSM Chapter 2300, Section 2303.3E(4)(a)

Health & safety issues identified and followed up (recipient's condition)	FE Contacts may be by telephone, but there must be a home visit to each recipient at least every three months, or more often if the recipient has indicated a significant change in status or if there are reasons for concern about health and safety. PD In addition to the [CSHA], individualized goals, risks, back-up plans, and follow-up on health and safety needs is addressed during the monthly contacts. PD The recipient will be informed that contact must be made with the case manager if there are any instances of health, safety, or welfare concerns, or when a significant change in their health status has occurred.	FE Appendix D: Participant-Centered Planning and Service Delivery, Section D-1: Service Plan Development (4)(d)(f) PD Appendix D: Participant-Centered Planning and Service Delivery, Section D-1: Service Plan Development (5)(e) PD Appendix D: Participant-Centered Planning and Service Delivery, Section D-1: Service Plan Development (4)(f)	FE During the monthly contact, the case manager monitors and documents the quality of care of the recipient. Quality of care includes the identification, remediation and follow-up of health and safety issues, needs and concerns of the recipient, waiver service satisfaction and whether the services are promoting goals stated in the POC. Effective 02/01/2021 FE "… promoting personalized goals stated in the POC." PD During the monthly contact, the direct service case manager monitors and documents the quality of care of the recipient. Quality of care includes the identification, remediation and follow-up of health and safety issues, needs and concerns of the recipient, waiver service satisfaction and whether the services are promoting goals stated in the POC.	FE MSM Chapter 2200, Section 2203.4A(4)(c) Effective 02/01/2021 FE MSM Chapter 220, Section 2203.3A(4)(c) PD MSM Chapter 2300, Section 2303.3E(4)(c)
Needs & concerns followed up and documented monthly (any changes in services or providers)	FE During the contacts, information such as: changes since last contact, medical appointments, new medications or treatments, hospitalizations, falls, waiver services meeting needs, any new or unmet needs, satisfaction with services, any equipment or supplies needed, or other information is gathered based on interview. PD Contacts may be by telephone, but there must be a home visit to each participant at least every 6 months or more often if the participant has indicated a significant change in health care status or if there are reasons for concern about health, safety, and welfare.	FE Appendix D: Participant-Centered Planning and Service Delivery, Section D-2: Service Plan Implementation and Monitoring (a) PD Appendix D: Participant-Centered Planning and Service Delivery, Section D-1: Service Plan Development (4 of 8), (d)(f)		

Waiver service satisfaction assessed monthly	FE Monthly contacts with the recipients are required to be initiated by the case manager to discuss the authorized services and evaluate the recipient's level of satisfaction. PD Monthly contacts with the recipients are required and initiated by the case manager to discuss the authorized services and evaluate the recipient's level of satisfaction.	FE Appendix D: Participant-Centered Planning and Service Delivery, Section D-1: Service Plan (4)(d)(f) PD Appendix D: Participant-Centered Planning and Service Delivery, Section D-1: Service Plan Development (4)(d) Service Plan Development Process (f)		
Personal goals assessed monthly	PD In addition to the [CSHA], individualized goals, risks, back-up plans, and follow-up on health and safety needs are addressed during the monthly contacts.	PD Appendix D: Participant-Centered Planning and Service Delivery, Section D-1: Service Plan Development (5)(e)		
Eligibility				
Assurance	**Waiver Requirement**	**Waivers**	**MSM Requirement**	**MSM Chapter**
Enrollee eligible on the date of service	FE/PD The Medicaid Management Information System (MMIS) assures that all claims for payment are made when the recipient was eligible for Medicaid waiver payment on the date of service, that the service was included in the recipient's approved service plan, and that the services were provided. This is accomplished through several subsystems within MMIS.	FE/PD Appendix I: Financial Accountability, Section I-2: Rates, Billing and Claims (3 of 3), (d)(a)	FE The State assures that claims for payment of waiver services are made only when an individual is Medicaid eligible, when the service is included in the approved POC, and prior authorization is in place when required. Effective 02/01/2021 FE The DHCFP assures that claims for payment of waiver services are made only when a recipient is Medicaid eligible, when the service is included in the approved POC, and PA is in place when required. PD The DHCFP must assure CMS all claims for payment of waiver services are made only when an individual is Medicaid eligible, when the service(s) are identified on the approved POC, and if the service(s) has been prior authorized.	FE MSM Chapter 2200, Section 2203.14 Effective 02/01/2021 FE MSM Chapter 2200, Section 2203.16 PD MSM Chapter 2300, Section 2303.15
Are there any conflicting services provided during the review month/service dates (*Institutional care*)	FE/PD In accordance with 42 CFR 441.301 (b)(1) (ii), waiver services are not furnished to individuals who are in-	FE/PD 6. Additional Requirements, B. Inpatients.	FE A recipient's case may be suspended, instead of closed if it is likely the recipient will be eligible again for waiver services within the next 60 days (for example, if a recipient	FE MSM Chapter 2200, Section 2204.1(a) PD MSM Chapter 2300, Section 2304.1A(1)

	patients of a hospital, an NF or ICF/IID.		is admitted to a hospital, nursing facility or ICF/MR). Effective 02/01/2021 FE A recipient's case must be suspended, instead of closed if it is likely the recipient will be eligible again for waiver services within the next 60 days. For example, if a recipient is admitted to a hospital, NF or Intermediate Care Facility for the Intellectually Disabled (ICF/IID). PD Recipients must be suspended when they are admitted to a hospital or an NF.	
Prior Authorization				
Assurance	**Waiver Requirement**	**Waivers**	**MSM Requirement**	**MSM Chapter**
Is service prior authorized	FE/PD Number and percent of recipients claims that are coded and paid correctly in accordance with the service plan, daily record, and prior authorization.	FE Appendix I: Financial Accountability, Section Quality Improvement: Financial Accountability (a)(i)(a) PD Appendix I: Financial Accountability, Section Quality Improvement: Financial Accountability (a)(i)	FE All providers may only provide services that have been identified in the POC and that, if required, have a prior authorization. Effective 02/01/2021 FE All providers may only provide services that have been identified in the POC and that, if required, have a Prior Authorization (PA). PD Administrative case management activities include...Completion of prior authorization form in the Medicaid Management Information System (MMIS).	FE MSM Chapter 2200, Section 2203.3B(1)(e) Effective 02/01/2021 FE MSM Chapter 2200, Section 2203.2B(1)(g) PD MSM Chapter 2300, Section 2303.1A(11)
Correct provider type	N/A	N/A	FE Must obtain and maintain a HCBW for the Frail Elderly provider number (Provider Type 48 or 57 as appropriate) through the DHCFP's QIO-like vendor. Effective 02/01/2021 FE Must obtain and maintain a provider number (Provider Type 48, 57 or 59 as appropriate) through the DHCFP's Fiscal Agent. PD Providers may also refer to the DHCFP's website for a complete list	FE MSM Chapter 2200, Section 2203.3B(1)(a) Effective 02/01/2021 FE MSM Chapter 2200, Section 2203.2B(1)(a) PD MSM Chapter 2300, Section 2303.15B

			of codes/modifiers billable under Provider Type 58.	
Procedure code/service level correct	FE/PD Performance Measure: Number and percent of recipients claims that are coded and paid correctly in accordance with the service plan, daily record, and prior authorization.	FE Appendix I: Financial Accountability, Section Quality Improvement: Financial Accountability, (a)(i)(a) PD Appendix I: Financial Accountability, Section Quality Improvement: Financial Accountability, (a)(i)	FE The State assures that claims for payment of waiver services are made only when an individual is Medicaid eligible, when the service is included in the approved POC, and prior authorization is in place when required. Effective 02/01/2021 FE The DHCFP assures that claims for payment of waiver services are made only when a recipient is Medicaid eligible, when the services is included in the approved POC, and PA is in place when required. PD The DHCFP must assure CMS all claims for payment of waiver services are made only when an individual is Medicaid eligible, when the services are identified on the approved POC, and if the services have been prior authorized.	FE MSM Chapter 2200, Section 2203.14 Effective 02/01/2021 FE MSM Chapter2200, Section 2203.16 PD MSM Chapter 2300, Section 2303.15
Daily Record				
Assurance	**Waiver Requirement**	**Waivers**	**MSM Requirement**	**MSM Chapter**
Services provided match the POC	FE Number and percentage of recipient's services that are delivered in accordance with the approved POC. PD The individual POC lists the services by scope, frequency, and duration. Case managers fax a copy of the appropriate POC to waiver providers and may go over the POC with waiver providers if requested. Providers are required to provide the services listed in the approved POC. The daily record verifies that services were provided in accordance with the approved POC.	FE Appendix D: Participant-Centered Planning and Service Delivery, Section Quality Improvement: Service Plan, (a)(i)(d) PD Appendix I: Financial Accountability Section I-2: Rates, Billing and Claims (3)(d)(b)	FE All providers may only provide services that have been identified in the POC and that, if required, have prior authorization. PD All Providers...may only provide services that have been identified in the recipient POC and, if required, have prior authorization.	FE MSM Chapter 2200, Section 2203.3B(1)(e) Effective 02/01/2021 FE MSM Chapter 2200, Section 2203.2B(1)(g) PD MSM Chapter 2300, Section 2303.3B(1)(d)

Frequency of Services match the POC	FE/PD Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.	FE Appendix D: Participant-Centered Planning and Service Delivery, Section Quality Improvement: Service Plan, (a)(i)(d) PD Appendix D: Participant-Centered Planning and Service Delivery, Section Quality Improvement: Service Plan, (a)(i)(b)		
Daily log signed by recipient	FE The claims are compared to the prior authorizations, POC and daily logs or timesheet signatures for accuracy. PD Waiver claims are pulled directly from the MMIS system and compared to the appropriate POC and daily records for verification of service delivery.	FE Appendix I: Financial Accountability, Section I-1: Financial Integrity and Accountability, (b) PD Appendix I: Financial Accountability Section I-2: Rates, Billing and Claims (3), (d)(c)	FE 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. Effective 02/01/2021 FE The recipient or, if applicable, the recipient's designated representative/Legally Responsible Individual (LRI) will…Sign the provider's daily/weekly record(s) to verify services were provides (except for case management and PERS). If the recipient is unable to provide a signature dude to cognitive and/or physical limitations, this will be clearly documented on the SOC and/or the case narrative. PD Each provider agency must have a file for each recipient. In the recipient's file, the agency must maintain the daily records. Periodically, the DHCFP Central Office staff may request this documentation to compare to billings submitted. These records must be maintained by the provider for at least six years after the date the claim is paid.	FE MSM Chapter 2200, Section 2203.3B(1)(h) Effective 02/01/2021 FE MSM Chapter 2200, Section 2203.2C(5) PD MSM Chapter 2300, Section 2303.3B(2)(a)(10)

Service units billed fall within the PA units allowed	FE/PD Performance Measure: Number and percent of recipients claims that are coded and paid correctly in accordance with the service plan, daily record, and prior authorization.	FE/PD Appendix I: Financial Accountability, Section Quality Improvement: Financial Accountability, (a)(i)(a) FE/PD Appendix I: Financial Accountability, Section Quality Improvement: Financial Accountability (a)(i)	FE May only provide services that have been identified in the recipient POC and, if required, have prior authorization. Effective 02/01/2021 FE All providers may only provide services that have been identified in the POC and that, if required, have a Prior Authorization (PA) PD All Providers...may only provide services that have been identified in the recipient POC and, if required, have prior authorization.	FE MSM Chapter 2200, Section 2203.3B(1)(e) Effective 02/01/2021 FE MSM Chapter 2200, Section 2203.2B(1)(g) PD MSM Chapter 2300, Section 2303.3B(1)(d)
Payment				
Assurance	**Waiver Requirement**	**Waivers**	**MSM Requirement**	**MSM Chapter**
Is the provider eligible for payment (active)	N/A	N/A	FE Must obtain and maintain a HCBW for the Frail Elderly provider number (Provider Type 48 or 57 as appropriate) through the DHCFP's QIO-like vendor. Effective 02/01/2021 FE All service providers: Must obtain and maintain a provider number (Provider type 48, 57, or 59 and appropriate) through the DHCFP's Fiscal Agent. PD Must enroll and maintain an active HCBW for Persons with Physical Disabilities provider number (type 58).	FE MSM Chapter 2200, Section 2203.3B(1)(a) Effective 02/01/2021 FE MSM Chapter 2200, Section 2203.2B(1)(a) PD MSM Chapter 2300, Section 2303.3B(1)(c)
Medicaid payment to the provider correct Services paid according to the Medicaid allowable rate	FE/PD A financial review is completed during the annual waiver review. The objective of this review is to confirm the accuracy of provider payments made by examining claims paid and comparing those claims with recipient files, Plans of Care, provider qualifications, waiver requirements and DHCFP policy.	FE/PD Appendix I: Financial Accountability Section I-1: Financial Integrity, Accountability, (b)	FE Providers must meet and comply with all provider requirements as specified in MSM Chapter 100. Effective 02/01/2021 FE In addition to this Chapter, the provider must also comply with rules and regulations for providers as set forth in the MSM Chapter 100 Medicaid Program. Failure to comply with any or all these stipulations may	FE MSM Chapter 2200, Section 2203.3B(1)(b) Effective 02/01/2021 FE MSM Chapter 2200, Section 2203.2B(1)(c) PD MSM Chapter 2300, Section 2303.3B(1)(b)

Overpayment to provider	FE If claims are found to be incorrect, a referral is made to DHCFP SURS unit to investigate under/over payments. PD If claims are discovered to be incorrect, a referral is made to the Surveillance and Utilization Recovery Unit (SURS) within DHCFP. This Unit investigates overpayments and underpayments.	FE Appendix I: Financial Accountability Section Quality Improvement: Financial Accountability, (a)(i)(b)(i) PD Appendix I: Financial Accountability, Section Quality Improvement: Financial Accountability (b)(i)	result in the DHCFP's decision to exercise its right to terminate the provider's contract. PD Providers must meet and comply with all provider requirements as specified in MSM Chapter 100.	
Referral to Surveillance and Utilization Review (SUR)				

Acronyms & Definitions

ACK	Acknowledgment Form	Used as shorthand for Acknowledgment Form NMO-7075
ADC/ADHC	Adult Day Care/Adult Day Health Care	An organized program of services during the day in a group setting for the purpose of supporting the personal independence of older adults and promoting their social, physical, and emotional well-being.
ADL	Activities of Daily Living	Self-care activities routinely performed daily, such as bathing, dressing, grooming, toileting, transferring, mobility, continence and eating.
ADSD	Aging and Disability Services Division	A State agency in Nevada's Department of Health and Human Services (DHHS) responsible for operating the Home and Community Based Services (HCBS) Waivers for the Frail Elderly, Physically Disabled, and Individuals with Intellectual Disabilities.
AL	HCBS Waiver for Assisted Living	A 1915(c) Waiver Program that provides assisted living services to individuals who are age 65 and older who, but for the provision of such services, would require a Nursing Facility (NF) level of care (LOC). This waiver was merged with the Waiver for the Frail Elderly (FE) effective July 1, 2015. Also used to refer to the service Assisted Living.
ALiS	Aithent Licensing System	Centralized database for provider reviews.
APC	Augmented Personal Care	Includes assistance and supervision with activities of daily living.
CFR	Code of Federal Regulations	The CFR is a codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the Federal government. The Code is divided into 50 titles which represent broad areas subject to federal regulation.
CM	Case Management/ Case Manager	Case management is a process by which an individual's needs are identified and social and medical services to meet those needs are located, coordinated, and monitored. Case management may be targeted to certain populations in certain areas of the state under the authority of Section 1905(a)(19) of the Social Security Act.
CMS	Centers for Medicare and Medicaid Services	The Federal government entity that monitors state programs to assure minimum levels of public health service are provided, as mandated in CFR Title 42.
CP	Care Plan	Plan of Care (POC)
CPAP	Continuous Positive Airway Pressure	Medical device
CPR	Cardiopulmonary Resuscitation	Cardiopulmonary resuscitation is a lifesaving technique useful in many emergencies, including heart attack or near drowning, in which someone's breathing or heartbeat has stopped. The American Heart Association recommends that everyone, untrained bystanders, and medical personnel alike, begin CPR with chest compressions.
CSHA/SHA	Comprehensive Social Health Assessment/Social Health Assessment	An assessment that addresses the recipient's activities of daily living (ADLs), which are self-care activities, such as bathing, dressing, grooming, transferring, toileting, ambulation, and eating. Instrumental activities of daily living (IADLs), which capture more complex life activities, are also assessed, including meal preparation, light housework, laundry, and essential shopping. In addition, this assessment includes information regarding the recipient's medical history and social needs. The assessment includes risk factors, back-up plans, equipment needs, behavioral status, current support system and unmet service needs.
DHCFP	Division of Health Care Financing and Policy	A State agency in Nevada's Department of Health and Human Services (DHHS) that works in partnership with the Centers for Medicare & Medicaid Services (CMS) to assist in providing quality medical care for eligible individuals and families with low incomes and limited resources.

DHHS	Department of Health and Human Services	The Department of Health and Human Services (DHHS) is an office of the Executive Branch of the State Government and is led by a director appointed by the Governor. DHHS is one of the largest departments in State government comprised of five Divisions including: Aging and Disability Services, Child and Family Services, Health Care Financing and Policy (Medicaid), Public and Behavioral Health, and Welfare and Supportive Services.
DME	Durable Medical Equipment	Medically necessary durable medical equipment that a doctor prescribes for use in the home.
DR/LRI	Designated Representative/ Legally Responsible Individual	Individuals who are legally responsible to provide medical support including: spouses of recipients, legal guardians, and parents of minor recipients, including: stepparents, foster parents, and adoptive parents.
DSS	Decision Support System	Database of Medicaid recipients and providers utilized by DHCFP QA for recipient selection for the review year as well as financial claims.
EAP	Energy Assistance Program	Program that provides a supplement to assist qualifying low-income Nevadans with the cost of home energy.
EVV	Electronic Visit Verification	AuthentiCare database containing information about clients, services, authorizations, providers, and workers used to verify claims created by providers and services received by recipients.
FBI	Federal Bureau of Investigation	The mission of the FBI—as a national security and intelligence organization—is to protect and defend the United States against terrorist and foreign intelligence threats, to uphold and enforce the criminal laws of the United States, and to provide leadership and criminal justice services to federal, state, municipal, and international agencies, and partners.
FE	HCBS Waiver for the Frail/Elderly	A 1915(c) Waiver Program (formerly Community Home Base Initiative Program) that provides the option of home and community-based services as an alternative to institutional nursing facility care and allows for maximum independence for the frail elderly who would otherwise need institutional nursing facility services.
GH	Group Home	A group home is a residence model of medical care for those with complex health needs.
HCBS/HCBW	Home & Community Based Services/Home & Community Based Waiver	Home and community-based services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community. These programs serve a variety of targeted populations groups, such as the frail elderly, people with mental illnesses, intellectual or developmental disabilities, and/or physical disabilities.
HCQC	Health Care Quality and Compliance	The Bureau of Health Care Quality and Compliance (HCQC) protects the safety and welfare of the public through the promotion and advocacy of quality health care through licensing, regulation enforcement, and education.
HIPAA	Health Insurance Portability and Accountability Act	The HIPAA of 1996 is a law to improve the efficiency and effectiveness of the health care system. HIPAA included a series of "administrative simplification: procedures that establish national standards for electronic health care transactions, and requires health plans (i.e., Medicaid and Nevada Check Up) and health care providers that process claims and other transactions electronically to adopt security and privacy standards to protect personal health information.
HMKR	Homemaker	Waiver service that includes assistance with general household chores. It can include housekeeping, laundry, shopping for groceries and other essential items, as well as the preparation of meals.
HUD	Department of Housing and Urban Development	The agency responsible for national policy and programs that address America's housing needs.
HV	Home Visit	Contact between case manager and recipient to assess services, goals, waiver satisfaction and any new needs.

IA	Initial Assessment	This assessment is conducted as an administrative function of the waiver program and evaluates service needs based on functional deficits, support systems, and imminent risk of institutionalization.
IADL	Instrumental Activities of Daily Living	Activities related to independent living including preparing meals, shopping for groceries or personal items, performing light or heavy housework, communication, and money management.
ICF	Intermediate Care Facility	Intermediate Care Facilities for individuals with Intellectual disability (ICF/ID) is an optional Medicaid benefit that enables states to provide comprehensive and individualized health care and rehabilitation services to individuals to promote their functional status and independence.
IID/MR	Intellectual Disabilities	A term used when there are limits to a person's ability to learn at an expected level and function in daily life.
LOC	Level of Care	The specification of the minimum amount of assistance that an individual must require in order to receive services in an institutional setting under the State Plan and home and community-based services waiver. LOCs are based on current assessments showing the level of functional skills and support needs. The assessments include psychological evaluation, medical records, nursing, and social assessments completed by professionals.
LTSS	Long Term Services and Supports	A unit within the Division of Health Care Financing and Policy that provides services specifically to Medicaid eligible recipients. This includes services for a diverse group of Nevadans including the elderly and people living with disabilities and special health care needs. LTSS provides both institutional and home and community-based care.
MC	Monthly Contact	Contact between case manager and recipient to assess services, goals, waiver satisfaction and any new needs.
MD	Medical Doctor	A licensed medical practitioner.
MDO	Medical/Dental/Ocular	A grouping of insurance coverage types/services noted within the SAMS system.
MFCU	Medicaid Fraud Control Unit	Statewide program that investigates and prosecutes Medicaid providers that obtain Medicaid funds through fraudulent means.
MMIS	Medicaid Management Information System	A computer system designed to help managers plan and direct business and organizational operations.
MSM	Medicaid Services Manual	The policies that govern Medicaid services.
MTM/MM	Medication Therapy Management/ Medication Management	MTM is a group of services that pharmacists and others can provide to find, treat, and educate patients with chronic conditions.
N/A	Not Applicable	Not Applicable
NF	Nursing Facility	NF is a general Nursing Facility, free-standing or hospital-based, which is licensed and certified by the Division of Public and Behavioral Health, Health Care Quality and Compliance, and provides both skilled and intermediate nursing services.
NMO	Nevada Medicaid Office	The Nevada Medicaid Office is responsible for policy, planning and administration of the Nevada Medicaid program; also known as the Division of Health Care Financing and Policy.
NOD	Notice of Decision	A Notice of Decision is sent to a waiver recipient for the following reasons: denial, suspension, reduction, and termination. The Notice of Decision outlines the recipient’s right to a Fair Hearing.
P&P Transmittal	Policy & Procedure Transmittal	The Policy and Procedure Transmittals are designed to provide a consistent format for communicating policy clarification within the Division of Health Care Financing and Policy and among sister agencies.
PA	Prior Authorization	A review conducted to evaluate medical necessity, appropriateness, location of service and compliance with Medicaid’s policy, prior to the delivery of service.

PCA/PCS	Personal Care Assistant/Service	Personal care assistants, also known as caregivers, home health or personal care aides, give assistance to people who are sick, injured, mentally or physically disabled, or the elderly and fragile. Hands-on assistance with activities of daily living (ADLs) (such as eating, bathing, dressing, and bladder and bowel requirements) or instrumental activities of daily living (IADLs) (such as taking medications and shopping for groceries).
PD	HCBS Waiver Serving People with Physical Disabilities	A 1915(c) Waiver Program that provides the option of home and community-based services as an alternative to institutional nursing facility care and allows for maximum independence for persons with physical disabilities who would otherwise need institutional nursing facility services.
PERS	Personal Emergency Response System	An electronic device which enables certain recipients at high risk of institutionalization to secure help in an emergency. The recipient may also wear a portable "help" button to allow for mobility. The system is connected to a landline and programmed to signal a response center once the "help" button is activated.
PES	Participant Experience Survey	An interview tool developed by Medstat Group, Inc. under a contract from the Centers for Medicare and Medicaid Services. The surveys capture data that can be used to calculate indicators for monitoring quality within the waiver programs.
POA	Power of Attorney	The authority to act for another person in specified or all legal or financial matters.
POC	Plan of Care	A written document identifying the recipient's health and welfare needs, along with goals and interventions to meet the identified needs. It specifies the level of assistance, type, amount, scope, duration, and frequency for all services, as well as other ongoing community support services that may meet the assessed needs of the recipient, regardless of the funding source.
PT/OT/ST	Physical Therapy/Occupational Therapy/Speech Therapy	Physical Therapy (PT) focuses on the acquisition and/or improvement of skills related to gross motor movement, such as sitting, standing, walking, jumping, running, and lifting. Occupational Therapy (OT) focuses on the acquisition of basic, self-help skills required for daily living. Speech-Language Therapy (ST) focuses on the acquisition and use of language.
QA	Quality Assurance	A structured, internal monitoring and evaluation process designed to improve quality of care. QA involves the identification of quality-of-care criteria, which establishes the indicators for program measurements and corrective actions to remedy any deficiencies identified in the quality of direct patient, administrative and support services.
QI	Quality Improvement	A critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.
QIO	Quality Improvement Organization	The QIO program focuses on three aims: better patient care, better population health, and lower health care costs through improvement.
QTC	Quarterly Telephone Contact	Contact between case manager and recipient to assess services, goals, waiver satisfaction and any new needs.
RA	Re-Assessment	Annual assessment of recipient eligibility and needs for waiver/non-waiver services.
SAMS	Social Assistance Management Software	Social Assistance Management Software or SAMS® manages consumer (recipient) and service data for social assistance organizations.
SNAP	Supplemental Nutrition Assistance Program	SNAP provides nutrition benefits to supplement the food budget of needy families so they can purchase healthy food and move towards self-sufficiency.

SOR	Serious Occurrence Report	A report of any actual or alleged event or situation involving either the provider/employee or recipient that relates substantial or serious harm to the safety or well-being of the provider/employee or recipient. Serious occurrences may include, but are not limited to the following: suspected physical or verbal abuse, unplanned hospitalization, neglect of the recipient, exploitation, sexual harassment or sexual abuse, injuries requiring medical intervention, an unsafe working environment, any event which is reported to Child or Elder Protective Services or law enforcement agencies, death of the recipient during the provision of Waiver Services, or loss of contact with the recipient for three consecutive scheduled days.
SOU/SOC	Statement of Understanding/Statement of Choice	A form given to all applicants describing the services offered under the waiver during the intake process and as required by each waiver. The assigned case manager informs the applicant of their choice between waiver services and placement in a long-term care facility, in addition to their choice of qualified providers.
SP	Service Plan	Plan of Care (POC)
SUR	Surveillance and Utilization Review	A statewide program that safeguards against unnecessary or inappropriate use of services by preventing excess payments in the Nevada Medicaid and Nevada Check Up programs. The SUR unit analyzes claims data to identify potential fraud, waste, overutilization, and abuse; collects provider overpayments and refers appropriate cases to the Medicaid Fraud Control Unit (MFCU) for criminal investigation and prosecution.
SW	Social Worker	Social Worker
TB	Tuberculosis	Tuberculosis is a potentially serious infectious disease that mainly affects the lungs. The bacteria that cause tuberculosis are spread from one person to another through tiny droplets released into the air via coughs and sneezes.
TBD	To Be Determined	To Be Determined
YTD	Year to Date	Year to Date