MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

January 26, 2021

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: JESSICA KEMMERER, RECIPIENT HIPAA PRIVACY & CIVIL RIGHTS OFFICER
/Jessica Kemmerer/

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

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 2200 – are being proposed to bring this chapter in line with the current waiver renewal which was approved on July 1, 2020.

Changes to this chapter include: updating the term "Home and Community-Based Waiver" (HCBW) to "Home and Community-Based Services" (HCBS) throughout the chapter to adhere to CMS guidance; changing the form referred as "NMO-2734" to "Waiver Eligibility Status Form" throughout the chapter; expanding the term "goals" to "personalized goals" throughout the chapter (as applicable); updated the term 'working day' to 'business day' throughout the chapter; updated the term "authorized representative" to designated representative," deleted the term "QIO-like vendor" throughout the chapter and identified the vendor as "fiscal agent" where applicable; added the term Legally Responsible Individual (LRI) throughout the chapter; and corrected the term from 'Waiver Unit' to 'LTSS Unit' throughout the chapter; deleting the term "program" from "waiver program" and replaced with waiver for clarity; added the titles to the Statues and Regulations throughout the chapter.

The policy was revised under Intake, Referral Prescreening process, Placement on the Waitlist and Waiver slot Allocation as the process has been updated and streamlined. Policy was revised in Suspended Waiver Services and reorganized.

The Assisted Living Waiver expired 6/30/14 and was combined with the Frail Elderly (FE) Waiver effective 7/1/2014. Some of the policy from the Assisted Living Waiver Chapter was added to the FE Waiver. Some sections within the FE Waiver were moved to organize the content, and to improve and clarify policies throughout the chapter.

Throughout the chapter, grammar, punctuation and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

Entities Financially Affected: None.

Financial Impact on Local Government: Unknown at this time.

These changes are effective February 01, 2021.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 03/21 CHAPTER 2200 – HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER FOR THE FRAIL ELDERLY	MTL 31/10, 38/11, 18/19, 22/12, 23/11 CHAPTER 2200 – HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER FOR THE FRAIL ELDERLY

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2200	**Introduction**	Terminology and acronyms were updated per the description provided in the Background and Explanation section above. The second paragraph was deleted and replaced with a reworded version that better reflects an overview of the waiver. Several sentences were moved from sections 2201 and modified for clarity.
2201	**Authority**	Terminology and acronyms were updated per the description provided in the Background and Explanation section above. Added the acronym for the Social Security Act – SSA. Updated the CFR to the appropriate citation style. Added "Section 3715 of the Care's Act, removed CFR 418; 431; 440; 441; 489; State Medicaid Manual Section 4440; Nevada's Home and Community Based Waiver for the Frail Elderly Control Number; and H.R. 6042 115th Congress.
2203.1	**Waiver Eligibility Criteria**	Terminology and acronyms were updated per the description provided in the Background and Explanation section above. This section was moved from 2203.2 to 2203.1. The language in this section was reworded for clarity. Added details of existing waiver eligibility requirements: must meet DWSS eligibility; additional requirements for Residential Group Homes for Seniors and Assisted Living Facility; added NAC 449 citation.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		The DHCFP approval and intake requirements have been removed as well as Administrative Case Management Activities.
2203.1A	**Coverage and Limitations**	This section was moved from 2203.2A to 2203.1A. Added clarifications regarding providing and reimbursement of services provided outside eligibility period; clarification in case the recipient is eligible for more than one waiver; criteria for participants in a hospice program; CARES Act guidelines. Deleted a sentence related to Wait List Priority, no policy was changed with the deletion. Clarification regarding changes of placement on the waitlist based on changes in condition/circumstances.
2203.1B	**Provider Responsibilities**	A portion of this section was moved from 2203.1B to 2203.11B.
2203.1C	**Recipients Responsibilities**	A portion of this section was moved from 2203.1C to 2203.11C.
2203.2	**Waiver Services**	This section was moved from 2203.3 to 2203.2.
2203.2A	**Coverage and Limitations**	This section was moved from 2203.3A to 2203.2A. Added language to clarify “remain in the community”.
2203.2B	**Provider Responsibilities**	This section was moved from 2203.3B to 2203.2B. Terminology and acronyms were updated per the description provided in the Background and Explanation section above. Sections have been reworded for clarity. Added Waivers for Adults in a facility based assisted living Provider Type (PT 59); clarified all providers must meet federal, state and local statutes, rules and regulations; added the right to terminate provider contracts for failure to comply with any or all stipulations; providers are responsible for claims submitted; clarified providers capacity and guidelines to provide services; The section regarding Criminal Background checks was updated and portion removed as it is outlined in MSM 100 and is duplicative.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Created new section #3 titled "Recipient Records"; removed paragraphs one to four; added PERS; deleted "Services for waiver recipients residing in a residential; expanded on the requirements of record keeping for the provider's documentation on claims, employees and recipients' files. Added 21st Century Cures Act. Updated NRS # from 449.037 to NRS # 449.0302, original NRS # has been changed, and added the title to the regulations listed within this section. Added information regarding the web based SOR Form available at the fiscal agent's website. Added 3 new reportable events under Incidents and Serious Occurrences. Deleted the "ADSD: in addition to" section an additional responsibilities remaining criteria regarding Criminal Background checks (this is duplicative, it is outlined in MSM 100). The Qualification and Training section added "abuse, neglect, and exploitation, including signs, symptoms, and prevention;" to subsection #5. Created sub-section under # 5: b. "Additional training requirements for Residential Group Homes for Seniors and Assisted Living Facilities" to list the training and qualifications applicable to residential facilities under this section.
2203.2C	**Recipients Responsibilities**	This section was moved from 2203.3 to 2203.2C. Terminology and acronyms were updated per the description provided in the Background and Explanation section above. The content was reorganized, and the language was updated/reworded for clarity. Added criteria of required environment for providers and staff. Added requirement to work with Case Manager and provider to create a back-up plan in case caregiver is unavailable to work. Added regarding annual face-to-face visit.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Added guidelines if case management is the only service provided, monthly contact is required. Added recipient is not eligible for EPSDT. Early and Periodic Screening, Diagnostic and Treatment section 2203.2D was removed.
2203.3	**Case Management**	This section was renumbered from 2203.4 to 2203.3 and subsequent sections numbered accordingly. Renamed from "Direct Service Case Management" to "Case Management". The language was updated/reworded for clarity.
2203.3A	**Coverage and Limitations**	Terminology and acronyms were updated per the description provided in the Background and Explanation section above. The content was reorganized, and the language was updated/reworded for clarity. Added language to #5 requiring inquiries and narration of recipient's choice to continue waiver services. The last sentence was moved down to create #11 and language was expanded for clarity. Added to detail due diligence regarding ongoing contacts with recipients as outlined in the POC.
2203.3B	**Providers Responsibilities**	Terminology and acronyms were updated per the description provided in the Background and Explanation section above.
2203.3C	**Recipients Responsibilities**	Terminology and acronyms were updated per the description provided in the Background and Explanation section above.
2203.4	**Homemaker Services**	This section was renumbered from 2203.5 to 2203.4, and all subsequent sections renumbered accordingly. The first sentence of #2 was moved up from Coverage and Limitations, language was added for clarity.
2203.4A	**Coverage and Limitations**	The following language was added "at the recipient's home, or place of residence (community setting)" and removed "by agencies enrolled as a Medicaid provider."

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2203.4B	**Provider Requirements**	Terminology and acronyms were updated per the description provided in the Background and Explanation section above.
2203.4C	**Recipients Responsibilities**	Expanded the acronym IVR, Interactive Voice Response.
2203.5	**Chore Services**	This section was renumbered from 2203.6 to 2203.5 and all subsequent sections renumbered accordingly. The beginning of #2 was moved up from 2203.5A Coverage and Limitations, language was added for clarity.
2203.5A	**Coverage and Limitations**	Minor deletions made for clarity and in accordance with the description provided in the Background and Explanation section above.
2203.5B	**Provider Responsibilities**	Replaced “Section” with “MSM.
2203.6	**Respite Care**	This section was renumbered from 2203.7 to 2203.6 and all subsequent sections renumbered accordingly. A portion was moved up from 2203.6A Coverage and Limitations, language was added to describe the services provided.
2203.6A	**Coverage and Limitations**	Language was added to clarify the period of services, the services are provided for the duration of the POC, and services must be prior authorized by ADSD.
2203.6B	**Provider Responsibilities**	Terminology and acronyms were updated per the description provided in the Background and Explanation section above. Replaced “Section” with “MSM. Deleted “perform general assistance with ADLs and IADLs and provide supervision to functionally impaired recipients in their private home;”.
2203.7	**Personal Emergency Response System**	This section was renumbered from 2203.8 to 2203.7 and all subsequent sections renumbered accordingly.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		The first item was moved up from 2203.7A Coverage and Limitations' Language was added to describe the services provided.
2203.7A	**Coverage and Limitations**	Added "The service component includes both, the installation of the device and monthly monitoring. Two separate authorizations are required for payment, the initial installation fee for the device and a monthly fee for ongoing monitoring; both are covered under the waiver."
2203.7B	**Provider Responsibilities**	Replaced "Section" with "MSM. Added monthly monitoring of the PERS device. Removed reference to Better Business Bureau as this is not a requirement for enrollment. Language was updated for clarity.
2203.7C	**Recipients Responsibilities**	This section was renumbered from 2203.9 to 2203.8 and all subsequent sections renumbered accordingly.
2203.8	**Adult Day Care Services**	A portion of #1 and all of #2 and #3 where moved up from 2203.8A Coverage and Limitations, language was added to describe the services provided.
2203.8A	**Coverage and Limitations**	Terminology and acronyms were updated per the description provided in the Background and Explanation section above. Added language to clarify timeframe of service. Added "Meals must be served in a manner suitable for the recipient and prepared with regard for individual preferences. Special diets and nourishments must be provided as ordered by the client's physician." Deleted "Reference MSM Chapter 1900 for transportation policies."
2203.8B	**Adult Companion Services**	This section was renumbered from 2203.10 to 2203.9 and all subsequent sections renumbered accordingly. Item 1 was moved up from 2203.9A Coverage and Limitations. Language was added to describe the services provided.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2203.9A	**Coverage and Limitations**	Language was updated for clarity. Added "Reference MSM Chapter 1900 Transportation Services for transportation policies."
2203.9B	**Provider Responsibilities**	Replaced "Section" with "MSM. Language was added for clarity.
2203.10	**Augmented Personal Care**	This section was renumbered from 2203.11 to 2203.10 and all subsequent sections renumbered accordingly. Terminology and acronyms were updated per the description provided in the Background and Explanation section above.
2203.10A	**Coverage and Limitations**	Deletion of the first item listed due to duplication. Added language and details regarding the recipient's placement on the waiver based on the recipient needs. Service Level definitions clarified and added definition for new SL4 approved at the 2017 legislative session for recipients with critical behaviors. Added clarification on reassessment due to changes and the need for providers to keep daily log documentation. Expanded on the definition of personalized care as established by CMS's new HCBS waivers rule. Added language from the Assisted Living chapter regarding core principles for residential facilities providing personalized care.
2203.10B	**Provider Responsibilities**	Replaced "Section" with "MSM. Terminology and acronyms were updated per the description provided in the Background and Explanation section above. Added language regarding the recipient's choice and satisfaction with services provided. Clarifying verbiage was added in accordance with CMS's new HCBS Waiver rules. Section regarding Recipient Records was added.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2203.10C	**Recipient Responsibilities**	Terminology and acronyms were updated per the description provided in the Background and Explanation section above.
2203.11	**Administrative Case Management Activities**	This was moved from original section 2203.1 to 2203.11. Subsequent sections (2203.1A Coverage and Limitations, 2203.1B Provider Responsibilities and 2203.1C Recipient Responsibilities) moved and renumbered accordingly. "Intake Procedures" was deleted.
2203.11A	**Coverage and Limitation**	Service activities updated for language clarity through section. Deleting repetitive wording. Terminology and acronyms were updated per the description provided in the Background and Explanation section above. Added screening for LOC determination of level of services offered and development of the POC details.
2203.11B	**Provider Responsibilities**	Added "In addition to the provider responsibilities listed in MSM 2203.3B Case Manager: Language was streamlined for clarity.
2203.11C	**Recipient Responsibilities**	Terminology and acronyms were updated per the description provided in the Background and Explanation section above.
2203.12	**Intake Procedures**	Terminology and acronyms were updated per the description provided in the Background and Explanation section above.
2203.12A	**Coverage and Limitations**	Terminology and acronyms were updated per the description provided in the Background and Explanation section above. Replaced 'intake worker' with "ADSD Intake Specialist" to identify the person that will contact the applicant. Updated the requirement for the initial contact for a new referral from 7 days to 15 working days per FE Waiver. Added information regarding time frame requirement to complete face-to- face assessment of 45days (previously 28 days and not included in FE chapter).

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Updated sub-section title from "No Waiver Slots Available" to "Placement on the Wait List"; the section was reworded for clarity. Added language to clarify applicant's placement on the waitlist while financial eligibility is determined and for a slot to become available. Updated sub-section title to "Waiver Slot Allocation". Added language to clarify that once a waiver slot becomes available a second face-to-face visit is required to complete the initial assessment. Added language regarding the procedure for the initial assessment process and requirements to complete the Comprehensive Social Health Assessment (CSHA), forms given to the applicant during assessment. Added time frame to indicate the CSHA is valid for 90 days for applicants on the waitlist. Updated the information the ADSD includes in the initial assessment packet and clarification of the approval/denial process between DHCFP and ADSD.
2203.13	**Annual Waiver Review**	This section was moved, now in section 2203.13.
2203.13A	**Coverage and Limitations**	This section was moved, now in section 2203.13A.
2203.13B	**Provider Responsibilities**	This section was moved, now in section 2203.13B. Updated verbiage to in accordance with Background and Explanation section above.
2203.15	**Provider Enrollment**	This section was moved, now in section 2203.12. Added PT numbers and location information of the enrollment checklist. Section title "2203.12A Coverage and Limitations" was deleted.
2203.16	**Billing Procedures**	This section was renumbered and is now 2203.16. Added link of the fiscal agent's website for Provider Billing Guide Manual information.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Deleted Coverage and Limitations and Provider Responsibilities sections, the information is duplicative of the Provider Billing Guide Manual.
2203.17	**Advance Directive**	This section was renumbered from 2203.15 to 2203.17. This section was moved, now in section 2203.16.
2204	**Hearings Requested Due to Adverse Actions**	The title of the section was updated from "Hearings" to "Hearings Requested Due to Adverse Actions". Added explanation of the hearings process due to adverse action taken on the waiver eligibility.
2204.1	**Suspended Waiver Services**	Terminology and acronyms were updated per the description provided in the Background and Explanation section above. The language was updated / reworded for clarity throughout section. Added new suspension reason due to an extended absence
2204.2	**Release from suspended waiver services**	The language was updated / reworded for clarity throughout section.
2204.3	**Denial of waiver application**	Language was updated/reworded for clarity throughout the section. Added note under letter 'm' to explain the Case Manager's responsibility to provide information on how to become a provider and assist as needed before terminating the recipient from waiver services.
2204.4	**Termination of waiver services**	Terminology and acronyms were updated per the description provided in the Background and Explanation section above. Deleted the first reason as the DHCFP or the ADSD do not terminate waiver services for that reason. Added note under letter 'o' to explain the Case Manager's responsibility to provide information on how

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		to become a provider and assist as needed before terminating the recipient from waiver services. Deleted the "ADSD" on the paragraph at the end of the section, as the Case Manager can be private or from the ADSD. Reworded the last paragraph of this section for clarification that one DWSS receives notification of the recipient's death, the DWSS need to notify ADSD and DHCFP. Added "Death of the recipient."
2204.5	**Reduction of waiver services**	Terminology and acronyms were updated per the description provided in the Background and Explanation section above.
2204.6	**Reauthorization within 90 days of waiver termination**	Introduction was moved from 2204.6A with updates to terminology, and acronyms were updated per the description provided in the Background and Explanation section above.
2204.6A	**Coverage and Limitations**	Terminology and acronyms were updated per the description provided in the Background and Explanation section above. Clarified process for slot allocation for what to do with the slot when someone enters a nursing facility (NF) or hospital. The slot is held 90 days from the date on the notice termination.
2204.6B	**Provider Responsibilities**	This was reworded for clarity.
2204.6C	**Recipients Responsibilities**	This was reworded for clarity.
2205	**Appeals and Hearings**	Added language to clarify the need to inform the applicants and recipients of the opportunity to request a Fair Hearing.

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HOME AND COMMUNITY BASED WAIVER (HCBW) FOR THE FRAIL ELDERLY

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2200 INTRODUCTION

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

The FE Waiver is an optional service approved by the Centers for Medicare and Medicaid Services (CMS), which authorizes the Division of Health Care Financing and Policy (DHCFP) the flexibility to design this waiver and select the mix of waiver services that best meet the goals of the program. This waiver allows the provision of services based on the identified needs and is designed to provide eligible Medicaid waiver recipients access to both state plan services as well as certain extended Medicaid covered services.

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

2201 AUTHORITY

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

Statutes and Regulations:

- Social Security Act: 1915(c) (HCBW)
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- Nevada Revised Statutes (NRS) Chapters 200 (Crimes Against the Person), 426 (Persons with Disabilities), 427A (Services to Aging Persons and Persons with Disabilities), 422 (Health Care Financing and Policy), 449 (Medical and Other Related Facilities), 616 (Industrial Insurance), 629 (Healing and Arts Generally)
- Nevada Administrative Code (NAC) Chapters 427A (Services to Aging Persons), 441A (Communicable Diseases), 449 (Medical and Other Related Facilities)
- 21st Century Cures Act, H.R. 34, Sec. 12006 – 114th Congress
- Section 3715 of the Care's Act

2202 RESERVED

2203 POLICY

2203.1 WAIVER ELIGIBILITY CRITERIA

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

Eligibility for Medicaid's HCBS Waiver is determined by the Aging and Disability Services Division (ADSD) and the Division of Welfare and Supportive Services (DWSS). These State agencies collaboratively determine eligibility for the Waiver as follows:

A. Waiver benefit plan eligibility is determined by ADSD by confirming the following criteria:

1. Applicants must be 65 years of age or older;

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

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

4. The applicant/recipient must require the provision of one waiver service at least monthly;

5. The applicant/recipient must have an adequate support system. This support system must be in place to ensure the physical, environmental and basic care needs of the applicant/recipient are met in order to provide a safe environment during the hours when home and community-based services are not being provided; and

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

B. Applicant must meet institutional income and resource guidelines for Medicaid as determined by the Division of Welfare and Supportive Services (DWSS).

C. Additional requirements for Residential Group Homes for Seniors and Assisted Living Facility:

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

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

2203.1A COVERAGE AND LIMITATIONS

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

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

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

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

5. Recipients of the HCBS Waiver who are enrolled or elect to enroll in a hospice program may be eligible to remain on the waiver if they require waiver services to remain in the community. Close coordination between the hospice agency and the waiver case manager is required to prevent any duplication of services. Refer to Medicaid Services Manual (MSM) Chapter 3200 for additional information on hospice services.

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

   a. identified in an individual's person-centered service plan (or comparable Plan of Care (POC);

   b. provided to meet needs of the individual that are not met through the provision of hospital services;

   c. not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and

   d. designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual's functional abilities.

7. The Waiver is limited by legislative mandate to a specific number of recipients who can be served through the waiver per year (slots). When no waiver slots are available, the ADSD

utilizes a wait list to prioritize applicants who have been presumed to be eligible for the waiver.

Wait List Priority:

a. Applicants currently in an acute care or NF and desiring discharge;

b. Applicants who require maximum assistance and/or are dependent in all three areas of eating, bathing, and toileting;

c. Applicants requiring services due to a crisis or emergency such as a significant change in support system;

d. Applicants transitioning from another waiver;

e. Applicants with a terminal illness; or

f. Applicants who do not meet the criteria for priority levels 1-5.

Applicants may be considered for an adjusted placement on the wait list based on significant change of condition/circumstances.

2203.1B PROVIDER RESPONSIBILITIES

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

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

2203.2 WAIVER SERVICES

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

2203.2A COVERAGE AND LIMITATIONS

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

1. Case Management.

2. Homemaker Services.

3. Chore Services.

4. Respite Care Services.

5. Personal Emergency Response System (PERS).

6. Adult Day Care Services.

7. Adult Companion Services.

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

2203.2B PROVIDER RESPONSIBILITIES

1. All Service Providers:

a. Must obtain and maintain a provider number (Provider Type 48, 57 or 59 as appropriate) through the DHCFP's Fiscal Agent.

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

c. 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 result in the DHCFP's decision to exercise its right to terminate the provider's contract.

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

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

f. Must understand that payment for services will be based on the level of service or specific tasks identified on the POC and will not be made to legally responsible individuals for furnishing waiver services.

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

h. Providers must verify the Medicaid eligibility status of each FE Waiver recipient each month.

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

demonstrate ability to understand, respect and maintain confidentiality in regards to the details of case circumstances.

2. Criminal Background Checks

The DHCFP policy requires all waiver providers and it's personnel, including owners, officers, administrators, managers, employees and consultants must undergo State and FBI background checks upon licensure and then at a minimum of every five years thereafter to ensure no convictions of applicable offenses have been incurred (ADSD personnel must follow State of Nevada policy regarding required background checks) and the safety of recipients is not compromised. For complete instructions, refer to the Division of Public and Behavioral Health (DPBH) website at http://dpbh.nv.gov.

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

3. Recipient Records

a. The number of hours specified on each recipient's POC, for each specific service listed except Case Management and PERS, will be considered the maximum number of hours allowed to be provided by the caregiver and paid by the DHCFP's fiscal agent, unless the case manager has approved additional hours due to a temporary condition or circumstance.

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

c. Provider agencies who are providing waiver services in the home must comply with the 21st Century Cures Act. Refer to Section 2203.14 of this chapter for detailed instructions.

4. Serious Occurrence Report (SOR):

Providers must report any recipient incidents, or issues regarding the provider/employee's ability to deliver services to the ADSD within 24 hours of discovery. Providers must complete the web-based Nevada DHCFP SOR Form, available at the fiscal agent's website at www.medicaid.nv.gov, under Providers Forms. A completed SOR form report must be made within five business working days and maintained in the agency's recipient record.

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

a. Suspected physical or verbal abuse;

b. Unplanned hospitalization;

c. Abuse, neglect, exploitation, isolation, abandonment, or unexpected death of the recipient;

d. Theft;

e. Sexual harassment or sexual abuse;

f. Injuries requiring medical intervention;

g. An unsafe working environment;

h. Any event which is reported to Adult Protective Services (ages 18 years old and above) or law enforcement agencies;

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

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

k. Medication errors resulting in injury, hospitalization, medical treatment or death.

l. Elopement of a recipient residing in a Residential Group Homes for Seniors or Assisted Living Facility.

The State of Nevada has established mandatory reporting requirements of suspected incidents of Elder Abuse, Neglect, Isolation Abandonment, and Exploitation. The ADSD and local law enforcement are the receivers of such reports. Suspected elder abuse must be reported as soon as possible, but no later than 24 hours after the person knows or has reasonable cause to believe that an elder person has been abused, neglected, isolated, abandoned or exploited. Refer to NRS 200.5091 to 200.50995 "Abuse, neglect, exploitation, isolation, abandonment, or isolation of older and vulnerable persons."

5. Adhere to HIPAA requirements.

Refer to MSM Chapter 100 for information on HIPAA, privacy and confidentiality of recipient records, and other protected health information.

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

7. Providers for Residential Group Homes for Seniors and Assisted Living Facility must obtain and maintain required HCQC licensure.

8. Qualification and Training:

a. All service providers must arrange training for employees who have direct contact with recipients of the FE Waiver and must have service specific training prior to performing a waiver service. Training at a minimum must include, but not limited to:

1. policies, procedures, and expectations of the agency relevant to the provider, including recipient's and provider's rights and responsibilities;

2. procedures for billing and payment;

3. record keeping and reporting including daily records and SORs;

4. information about the specific needs and goals of the recipients to be served; and

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

b. Additional training requirements for Residential Group Homes for Seniors and Assisted Living Facilities:

In addition to the requirements listed above under Section 2203.2B(8)(a):

1. Caregivers of a residential facility for groups must be at least 18 years of age; be responsible and mature and have the personal qualities which will enable him or her to understand the problems of the aged and disabled; demonstrate the ability to read, write, speak and understand the English language; must possess the appropriate knowledge, skills and abilities to meet the needs of the residents of the facility and annually receive no less than eight hours of training related to providing for the needs of the residents of a residential facility for groups as outlined in the NAC 449.3975 "Attendants, Qualifications; annual training," must be knowledgeable in the use of any prosthetic devices or dental, vision or hearing aids that the residents use and must understand the provisions of NAC 449.156 to NAC 449.27706, "Residential Facilities for Groups" inclusive, and Sections 2 and 3 of the regulation, and sign a statement that he/she has read those provisions as outlined in NAC 449.196 "Qualifications and training of caregivers."

2. If a caregiver assists a resident of a Residential Group Home for Seniors and Assisted Living Facility in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver must: before assisting a resident in the administration of a medication, receive the training required pursuant to paragraph (e) of Subsection 6 of NRS 449.032 "Medical and other Related Facilities," which must include, at least 16 hours of training in the management of medication consisting of not less than 12 hours of classroom training and not less than four hours of practical training, and obtain a certificate acknowledging the completion of such training; receive annually at least eight hours of training in the management of medication and provide the Residential Group Homes for Seniors and Assisted Living Facility with satisfactory evidence of the content of the training and his or her attendance at the training; complete the training program developed by the administrator of the Residential Group Homes for Seniors and Assisted Living Facility pursuant to paragraph (e) of Subsection 1 of NAC 449.2742 "Administration of Medication: Responsibilities of administrator, caregivers and employees of facility," and annually pass an examination related to the management of medication approved by the HCQC as outlined in NAC 449.196 "Qualifications and trainings of caregivers."

3. Within 30 calendar days after a caregiver is employed at the Residential Group Homes for Seniors and Assisted Living facility, a caregiver must be trained in First Aid and Cardiopulmonary Resuscitation (CPR) as described in NAC 449.231 "First Aid and Cardiopulmonary resuscitation" and be able to recognize and appropriately respond to medical and safety emergencies.

4. Caregivers staff providing direct care and support to residents must have training specific to the waiver population being cared for at the Residential Group Homes for Seniors and Assisted Living Facility, including the skills needed to care for recipients with increasing functional, cognitive and behavioral needs. Training will include, but not limited to, techniques such as transfers, mobility, positioning, use of special equipment, identification of signs of distress, First Aid and CPR.

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

c. Exemptions from Training for Provider Agencies:

1. The provider agency may exempt a prospective service provider from those parts of the required training where the agency judges the person to possess

adequate knowledge or experience, or where the provider's duties will not require the particular skills.

2. The exemption and its rationale must be provided in writing and a copy of the exemption must be placed in the employee's file.

3. ADSD/DHCFP may review exemptions for appropriateness.

2203.2C RECIPIENT RESPONSIBILITIES

The recipient or, if applicable, the recipient's designated representative/Legally Responsible Individual (LRI) will:

1. Notify the provider(s) and the Case Manager of any change in Medicaid eligibility;

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

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

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

5. Sign the provider's daily/weekly record(s) to verify services were provided (except for Case Management and PERS). If the recipient is unable to provide a signature due to cognitive and/or physical limitations, this will be clearly documented on the SOU and/or the case narrative;

6. Notify the provider or the Case Manager when scheduled visits cannot be kept or services are no longer required;

7. Notify the provider agency or the Case Manager of any missed appointments by the provider agency staff;

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

9. Furnish the provider agency with a copy of his or her Advance Directive;

10. Work with the Case Manager and/or provider agency to establish a back-up plan in case the caregiver is unable to work at the scheduled time;

11. Understand that a provider may not perform services or work more hours than authorized in the POC;

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

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

14. Understand that if case management is the only HCBS Waiver service, a monthly contact with the Case Manager is required;

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

16. Contact the Case Manager to request a change of provider agency;

17. Complete, sign and submit all required forms on a timely basis; and

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

19. Recipients of this waiver are not eligible for EPSDT.

2203.3 CASE MANAGEMENT

Case management service is provided to eligible recipients in the HCBS Waivers when case management is identified as a service on the POC. The recipient has a choice of case management provided by ADSD or a private case management agency (must be enrolled as a Medicaid provider agency).

2203.3A COVERAGE AND LIMITATIONS

These services include (not all inclusive):

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

2. Coordination of multiple services and/or providers when applicable;

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

4. Monitoring and documenting the quality of care through contact with recipients:

   a. 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.

b. When recipient service needs increase, due to a temporary condition or circumstance, the case manager must thoroughly document the increased service needs in their case narrative. 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 calendar days. If the recipient is utilizing a private case management agency, this information must be communicated to the ADSD for PA adjustment.

c. During the ongoing contact or face-to-face visit, 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, risk factors, needs and concerns of the recipient, waiver service satisfaction and whether the services are promoting personalized goals stated in the POC. The case manager also assesses the need for any change in services or providers. If the recipient is utilizing a private case management agency, this information must be communicated to the ADSD for PA adjustment.

d. During scheduled visits to a Residential Group Homes for Seniors and Assisted Living Facility, the case manager is responsible for reviewing the POC and daily logs as applicable for feedback from the recipient to help ensure services are delivered as authorized in the POC. In addition, the case manager is responsible for reviewing the medication log to ensure appropriate administration and documentation is completed timely.

5. Ensure the recipient retains freedom of choice in the provision of services. During the contacts with the recipient, the case manager must inquire and narrate the recipient's choice to continue receiving waiver service;

6. Notifying all affected providers of changes in the recipient's medical status, service needs, address, or of changes of the status of designated representative/LRI;

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

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

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

10. The Case Managers must provide recipients with appropriate amount of case management services necessary to ensure the recipient is safe and receives sufficient services. Case management will be considered an "as needed" service.

11. When case management is the only waiver service identified in the POC, the Case Managers shall continue to have monthly contact with recipients and/or the recipient's designated representative/LRI of at least 15 minutes (equal to one unit), per month. The duration, scope, and frequency of case management services billed to the DHCFP must be adequately documented and substantiated by the Case Manager's narratives.

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

13. Monitoring to assure providers of Residential Group Homes for Seniors and Assisted Living Facility meet required program standards.

14. Arranging for the relocation of the recipient, if necessary, when an alternative placement is requested or needed.

2203.3B PROVIDER RESPONSIBILITIES

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

1. Be currently licensed as Social Worker by the State of Nevada Board of Examiners for Social Workers or licensure as a Registered Nurse by the Nevada State Board of Nursing.

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

In addition, private Case Managers must:

a. Have one--year experience of working with seniors in a home--based environment.

b. Provide evidence of taxpayer ID number, Workman's Compensation Insurance, Unemployment Insurance Account, Commercial General Liability, Business Automobile Liability Coverage and Commercial Crime Insurance.

c. Be employed by a private case management provider agency.

2203.3C RECIPIENT RESPONSIBILITIES

1. Each recipient and/or designated representative/LRI must cooperate with the implementation of services and the implementation of the POC.

2. Each recipient is to comply with the rules and regulations of the DHCFP, ADSD, DWSS and the FE Waiver.

2203.4 HOMEMAKER SERVICES

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

2203.4A COVERAGE AND LIMITATIONS

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

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

3. The DHCFP/ADSD is not responsible for replacing goods which are or become damaged in the provision of service.

4. Homemaker services include:

   a. Meal preparation: menu planning, storing, preparing, serving of food, cutting up food, buttering bread and plating food;

   b. Laundry services: washing, drying, and folding the recipient's personal laundry and linens (sheets, towels, etc.) excludes ironing. Recipient is responsible for all laundromat and/or cleaning fees;

   c. Light housekeeping: changing the recipient's bed linens, dusting, vacuuming the recipient's living area, cleaning kitchen and bathroom areas;

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

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

5. Activities the homemaker shall not perform and for which Medicaid will not pay include the following:

   a. transporting the recipient in a private car;

   b. cooking and cleaning for the recipient's guests, other household members or for the purposes of entertaining;

   c. repairing electrical equipment;

d. ironing and mending;

e. giving permanents, dyeing or cutting hair;

f. accompanying the recipient to appointments, social events or in-home socialization;

g. washing walls and windows;

h. moving heavy furniture, climbing on chairs or ladders;

i. purchasing alcoholic beverages that were not prescribed by the recipient's physician;

j. doing yard work such as weeding or mowing lawns, trimming trees, shoveling non-essential snow-covered areas, and vehicle maintenance; or

k. care of pets except in cases where the animal is a certified service animal.

2203.4B PROVIDER RESPONSIBILITIES

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

1. Arrange and receive training related to household care, including good nutrition, special diets, meal planning and preparation, shopping information, housekeeping techniques, and maintenance of a clean, safe and healthy environment; and

2. Inform recipients that the ADSD, the DHCFP or its fiscal agent is not responsible for replacement of goods damaged in the provision of service.

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

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

2203.4C RECIPIENTS RESPONSIBILITIES

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

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

2203.5 CHORE SERVICES

Chore services are intermittent in nature and may be authorized as a need arises for the completion of a specific task which otherwise left undone poses a home safety issue. Services needed to maintain a clean, sanitary, and safe home environment. The service must be identified on the POC, is approved by the ADSD CM, authorization must be in place and must be clearly documented on the Comprehensive Social Health Assessment (CSHA) the need for Chore service. These services are provided only in cases where neither the recipient, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer/agency or third party payer is capable of, or responsible for, their provision and without these services the recipient would be at risk of institutionalization.

2203.5A COVERAGE AND LIMITATIONS

1. This service includes heavy household chores in the private residence such as:

   a. cleaning windows and walls;

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

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

   d. packing and unpacking for the purpose of relocation;
   e. minor home repairs; or

   f. removing trash and debris from the yard.

2. This is not a skilled, professional service.

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

2203.5B PROVIDER RESPONSIBILITIES

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

1. be able to read, write and follow written or oral instructions;

2. have experience and/or training in performing heavy household activities and minor home repair; and

3. maintain the home in a clean, sanitary and safe environment if performing heavy household chores and minor home repair services.

Providers are responsible to ensure that EVV requirements and expectations are met, including the documentation of all services in approved EVV System.
Service must be prior authorized and documented in an approved EVV System.

2203.5C RECIPIENTS RESPONSIBILITIES

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

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

2203.6 RESPITE CARE

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

2203.6A COVERAGE AND LIMITATIONS

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

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

3. Services must be prior authorized by ADSD.

2203.6B PROVIDER RESPONSIBILITIES

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

1. Have the ability to read and write and to follow written or oral instructions;

2. Have had experience in providing for the personal care needs of people with functional impairments;

3. Demonstrate the ability to perform the care tasks as prescribed;

4. Be tolerant of the varied lifestyles of the people served; and

5. Provide training in personal hygiene needs and techniques for assisting with ADLs, such as bathing, grooming, skin care, transferring, ambulating, feeding, dressing and use of adaptive aids and equipment, homemaking and household care.

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

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

2203.6C RECIPIENTS RESPONSIBILITIES

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

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

2203.7 PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)

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

2203.7A COVERAGE AND LIMITATIONS

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

2. The service component includes both, the installation of the device and monthly monitoring. Two separate authorizations are required for payment, the initial installation fee for the device and a monthly fee for ongoing monitoring; both are covered under the waiver.

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

2203.7B PROVIDER RESPONSIBILITIES

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

1. Be responsible for ensuring that the response center is staffed by trained professionals at all times;

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

3. Utilize devices that meet Federal Communication Commission standards, Underwriter's Laboratory, Inc. (UL) standards or equivalent standards;

4. Inform recipients of any liability the recipient may incur as a result of the recipient's disposal of provider property.

2203.7C RECIPIENT RESPONSIBILITIES

1. The recipient is responsible to utilize the leased PERS equipment with care and caution and to notify the PERS provider and Case Manager if the equipment is no longer working.

2. The recipient must return the equipment to the provider when the recipient no longer needs or utilizes the equipment, when the recipient terminates from the waiver program or when the recipient moves from the area.
3. The recipient must not dispose or damage the PERS equipment. This is leased equipment and belongs to the PERS provider.

2203.8 ADULT DAY CARE SERVICES

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

It is provided on a regularly scheduled basis, in accordance with the goals in the recipient's POC.

2203.8A COVERAGE AND LIMITATIONS

1. The emphasis is on social interaction in a safe environment. The POC must indicate the number of days per week the recipient will attend.

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

3. Service utilization and billing method (per diem/unit rate) will be prior authorized as indicated in the recipient's POC. The per diem rate is authorized when the recipient is in attendance for six or more hours per day, and the unit rate is authorized for attendance of a minimum of four hours and up to six hours per day. Providers must bill in accordance

with the approved PA, even if the recipient occasionally attends less than six hours. If the recipient's overall pattern changes and consistently attends less than six hours a day, a change to the POC and PA will be required to update the service utilization and billing method.

4. Providers must not bill for days a recipient is not in attendance, even if it is a regularly scheduled day. Providers must keep attendance records for each recipient. Claims must reflect dates and times of service as indicated on the attendance records.

2203.8B PROVIDER RESPONSIBILITIES

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

Meet and maintain the service specifications as an adult day care provider as outlined in NAC 449 "Medical Facilities and other Related Entities."

2203.9 ADULT COMPANION SERVICES

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

2203.9A COVERAGE AND LIMITATIONS

1. Adult companions may assist or supervise the recipient with tasks as meal preparation and clean up, light housekeeping, shopping and facilitate transportation/escort as needed. These services are provided as an adjunct to the Adult Day Care Services and must be incidental to the care and supervision of the recipient.

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

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

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

2203.9B PROVIDER RESPONSIBILITIES

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

1. Be able to read, write and follow written or oral instructions; and

2. Have experience or training in how to interact with recipients with disabling and various health conditions.

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

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

2203.9C RECIPIENTS RESPONSIBILITIES

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

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

2203.10 AUGMENTED PERSONAL CARE

Augmented Personal Care (APC) provided in a licensed Residential Group Homes for Seniors or Assisted Living Facility is a 24-hour in home service that provides assistance for functionally impaired elderly recipients with basic self-care and ADLs that include as part of the service:

A. Homemaker Services;

B. Personal Care Services;

C. Chore Services;

D. Companion Services;

E. Therapeutic social and recreational programming;

F. Medication oversight (to the extent permitted under State Law); and

G. Services which will ensure that residents of the facility are safe, secure, and adequately supervised.

This care is over and above the mandatory service provision required by regulation for Residential Group Homes for Seniors and Assisted Living Facility.

2203.10A COVERAGE AND LIMITATIONS

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

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

3. There are four service levels of APC. The service level provided is based on the recipient's functional needs to ensure the recipient's health, safety and welfare. The ADSD Case Manager determines the service level as an administrative function of the FE Waiver.

   a. Level One Daily (minimum assistance):

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

   b. Level Two Daily (moderate assistance):

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

   c. Level Three Daily (maximum assistance):

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

   d. Level Four (Critical Behaviors):

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

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

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

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

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

4. Section 1903(a)(1) of the SSA provides funding for Federal Financial Participation (FFP) to States for expenditures for services under an approved State Plan. FFP is not available to subsidize the cost of room and board furnished in a Residential Group Homes for Seniors and Assisted Living Facility. The cost for room and board is a private agreement between the recipient and the Residential Group Homes for Seniors or Assisted Living Facility.

5. Nursing and skilled services (except periodic nursing evaluations) are incidental, rather than integral to the provision of group care services. Payment will not be made for 24-hour skilled care or supervision.

6. Other individuals or agencies may also furnish care directly, or under arrangement with the Residential Group Homes for Seniors or Assisted Living Facility. However, the care provided by these other entities supplements what is being provided but does not supplant it.

7. Personalized care furnished to individuals who choose to reside in a Residential Group Homes for Seniors or Assisted Living Facility based on their individualized POC, which is developed with the recipient, people chosen by the recipient, caregivers and the Case Manager. Care must be furnished in a way that fosters the independence of each recipient.

8. The Residential Group Homes for Seniors or Assisted Living Facility provides personalized care to the residents, and the general approach to operating the facility incorporates these core principles:

   a. Designed to create a residential environment that actively supports and promotes each resident's quality of life and right to privacy.

   b. Committed to offering high-quality supportive services that are developed by the facility in collaboration with the recipient's individual needs.

   c. Provides a variety of creative and innovative services that emphasize the specific needs of each recipient and the personal choice of lifestyle.

d. Operate and interact with recipients to support recipient's need for autonomy and the right to make decisions.

e. Designed to foster a social climate that allows the recipient to develop and maintain personal relationships with fellow residents and with persons in the general community.

f. Minimize the need for its recipients to move out of the facility as their respective physical and mental conditions change over time.

g. Foster a culture that provides a high-quality environment for the recipients, their families, the staff, any volunteers, and the community at large.

2203.10B AUGMENTED PERSONAL CARE PROVIDER RESPONSIBILITIES

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

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

2. The provider for a Residential Group Homes or Assisted Living Facility must:

a. Notify the ADSD Case Manager within three business days when the recipient states the desire to leave the facility.

b. Participate with the ADSD Case Manager in discharge planning.

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

d. Notify the ADSD of any incidents pertaining to a waiver recipient that could affect the health, safety, or welfare.

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

f. Provide the ADSD with at least a 30-calendar days' notice before discharging a recipient unless the recipient's condition deteriorates and warrants immediate discharge. When the Case Manager is notified, they assist in relocation and working with staff on transfers/discharges.

g. Privacy, dignity, and respect are maintained during the provisions of services. Living units are not entered without permission.

h. Conduct business in such a way the recipient is free from coercion and restraint and retains freedom of choice. Residential Group Homes and Assisted Living Facility must provide services based on the recipient's choice, direction, and preferences.

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

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

k. Provide services to FE Waiver eligible recipients in accordance with the recipient's POC, the rate, waiver limitations, and procedures of the DHCFP.

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

m. Have sufficient caregivers present at the facility to conduct activities and provide care and protective supervision for the residents at all times. The provider must comply with HCQC staffing requirements for the specific facility type (for example, an Alzheimer facility).

n. There must be 24-hour on site staff to meet scheduled or unpredictable needs and provide supervision, safety and security, and transportation if one or more residents are present.

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

p. Each recipient must have privacy in their sleeping or living unit:

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

2. Recipients sharing units have a choice of roommate.

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

3. Recipient Records

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

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

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

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

d. Services for waiver recipients residing in a Residential Facility for Groups and Assisted Living Facility should be provided as specified on the POC and at the appropriate authorized service level.

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

2203.10C RECIPIENT RESPONSIBILITIES

1. Recipients are to cooperate with the providers of Residential Group Home for Seniors or Assisted Living Facility in the delivery of services.

2. Recipients are to report any problems with the delivery of services to the Residential Group Homes for Seniors or Assisted Living Facility administrator and/or ADSD Case Manager.

2201.11 ADMINISTRATIVE CASE MANAGEMENT ACTIVITIES

Administrative case management activities are performed by ADSD case managers and refer to data collection for eligibility verification, LOC evaluation, POC development, and other case management activities that are not identified on the POC.

2203.11A COVERAGE AND LIMITATIONS

Administrative case management activities include:

1. Processing of Intake referrals;

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

3. Preliminary and ongoing assessments, evaluations and completion of forms required for service eligibility such as:

   a. Screening assessment for the LOC to determine if the individual has functional deficits and requires the level of service offered in a NF or a more integrated service that may be community-based.

   b. 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 recipient's LOC, functional status and needs addressed by the POC must be reassessed annually or more often as needed. The recipient must also be reassessed when there is a significant change in his/her condition which influences eligibility.

4. Request issuance of Notices of Decision (NOD) to the DHCFP LTSS when a waiver application is denied;

5. Coordination of care and services and collaboration in discharge planning to transition applicants;

6. Obtaining the necessary documentation for case files prior to applicant's eligibility;

7. Case closure activities upon termination of service eligibility;

8. Outreach activities to educate recipients or potential recipients on how to access into care and services through various Medicaid Program;

9. Distribution of the POC to all affected providers;

10. Ensure completion of PA form, if required, for all waiver services identified on the POC for submission into the Medicaid Management Information System (MMIS) Inter-Change.

2203.11B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in MSM Section 2203.2B Case Manager:

1. Must be currently licensed as a Social Worker by the State of Nevada Board of Examiners for Social Workers or as a Registered Nurse by the Nevada State Board of Nursing.

2. Must have a valid driver's license and the ability to conduct home visits.

3. Must adhere to HIPAA requirements.

4. Must have a Federal Bureau of Investigation (FBI) criminal history background check.

2203.11C RECIPIENT RESPONSIBILITIES

1. Applicant/recipients and/or their designated representative/LRI must cooperate with the ADSD by assisting with the assessment and reassessment process, accurately representing skill level needs, wants, resources and personalized goals.

2. Applicants/recipients and/or their designated representative/LRI together with the case manager must develop and/or review the POC.

2203.12 INTAKE PROCEDURES

ADSD has developed policies and procedures to ensure fair and adequate access to the FE Waiver.

2203.12A COVERAGE AND LIMITATIONS

1. Referral

a. A referral or inquiry for the FE waiver may be initiated by phone, mail, fax, in person, email or by an applicant or another party on behalf of the applicant.

b. The ADSD intake specialist will make phone/verbal contact with the applicant/ designated representative/LRI within 15 working days from the referral date.

c. If the applicant appears to be eligible, a face-to-face visit must be scheduled and completed within 45 calendar days from the referral date to assess eligibility including the NF LOC determination.

If the ADSD intake specialist determines during the face-to-face visit the applicant does not appear to meet the FE waiver criteria financial eligibility, LOC, or waiver

service need, the applicant will be referred to other agencies for any needed services or assistance.

d. If the applicant does not meet the FE Waiver criteria, the applicant must be verbally informed of the right to continue the Medicaid application process through the DWSS. If the DWSS determines the applicant to be ineligible for Medicaid, the applicant may have the right to a fair hearing through the DWSS.

2. Placement on the: Wait List.

a. Once the ADSD has identified the applicant meets the LOC and has a waiver service need, the applicant is placed on the wait list by priority and referral date.

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

c. If it has been determined no slot is expected to be available within the 90 calendar days determination period, a notification letter is sent to the applicant indicating "No slot is available."

3. A Waiver Slot Allocation:

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

The procedure used for processing an applicant is as follows:

a. The ADSD Case Manager will conduct a second face-to-face interview with the applicant to complete the initial assessment.

b. The initial assessment includes addressing ADLs, IADLs, service need, support system and personalized goals.

c. An Authorization for the Use and Disclosure of Protected Health Information Form is needed for all waiver applicants and provides written consent for the ADSD to release information about the applicant to others.

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

e. The applicant will be given the right to choose waiver services in lieu of placement in a NF. If the applicant and/or legal representative prefers placement in a nursing facility, the case manager will assist the applicant in arranging for facility placement.

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

4. The ADSD will send the HCBS Waiver Eligibility Status Form to DWSS for review and approval of Medicaid application:

5. On a monthly basis, the DHCFP Long Term Services and Supports (LTSS) Unit will review a random sample of intake packets for completeness to ensure waiver requirements are being met. The intake packet for review must include:

a. The current CSHA with the following items embedded:

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

2. At least one waiver service need identified;

3. The narrative section of the assessment confirming a face-to-face visit was conducted for the initial assessment

b. the Statement of Understanding/Choice (SOU) must be complete with signature and dates; and

c. The HCBS Acknowledgement Form completed including initials, signature, and date.

d. All forms must be completed with initials, 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.

e. The applicant has been informed of their right to participate in the development of the POC using the person-centered approach with the support systems, friends, family of their choice involved. Applicants will be given free choice of all qualified Medicaid providers of each Medicaid covered service included in the written POC. Current POC information as it relates to the services provided must be given to all service providers.

6. Once DWSS have approved the application, waiver service can be initiated;

7. If the application is denied, DWSS will send a denial NOD to the applicant.

If the applicant is denied by ADSD for waiver services, the ADSD will submit the HCBS Waiver Eligibility Form to the DHCFP LTSS unit requesting a denial NOD be sent to the applicant. The request must include the reason(s) for the denial. The DHCFP LTSS unit will send the applicant the denial NOD. The DHCFP will return the processed HCBS Waiver Eligibility Form and a copy of the NOD to ADSD for their record.

8. Effective Date for Waiver Services

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

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

9. Waiver Cost

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

2203.13 ANNUAL WAIVER REVIEW

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

2203.13A COVERAGE AND LIMITATIONS

The State conducts an annual review; collaboratively with the ADSD, with the DHCFP being the lead agency. The CMS has designated waiver assurances and sub-assurances which states must include as part of an overall quality improvement strategy. The annual review is conducted using the state specified performance measures identified in the approved FE waiver to evaluate operation.

The DHCFP:

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

2. Assures financial accountability for funds expended for HCBS Waiver services;

3. Evaluates that all provider standards are continuously met, and that the POCs are periodically reviewed to assure that the services furnished are consistent with the identified needs of the recipients;

4. Evaluates the recipients' satisfaction with the waiver using Personal Experience Survey (PES) conducted with a random sampling of the recipients to ensure waiver satisfaction. Interviews will be completed throughout the year; and

5. Further assures that all problems identified by this monitoring will be addressed by the provider in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

2203.13B PROVIDER RESPONSIBILITIES

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

2203.14 ELECTRONIC VISIT VERIFICATION (EVV):

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

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

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

A. STATE OPTION:

1. The EVV system electronically captures:

a. The type of service performed, based on procedure code;

b. The individual receiving the service;

c. The date of the service;

d. The location where service is provided;

e. The individual providing the service;

f. The time the service begins and ends.

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

a. The agency/personal care attendant's smartphone;

b. The agency/personal care attendant's tablet;

c. The recipient's landline telephone;

d. The recipient's cellular phone (for Interactive Voice Response (IVR) purposes only);

e. Other GPS-based device as approved by the DHCFP.

B. DATA AGGREGATOR OPTION:

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

a. Appropriate form must be approved by the DHCFP before use of system to ensure all data requirements are being collected to meet the 21st Century Cures Act.

b. At a minimum, data uploads must be completed monthly into data aggregator.

2203.15 PROVIDER ENROLLMENT

To become a Waiver provider, as a Provider Type (PT) 48, PT 57 or PT 59, providers must comply with all the DHCFP fiscal agents. Enrollment checklist and forms can be found on the fiscal agent's website at www.medicaid.nv.gov.

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

2203.16 BILLING PROCEDURES

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.

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

2203.17 ADVANCE DIRECTIVES

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

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

2204 HEARINGS REQUESTS DUE TO ADVERSE ACTIONS

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

2204.1 SUSPENDED WAIVER SERVICES

A. A recipient's case must be suspended, instead of closed if it is likely the recipient will be eligible again for waiver services within the next 60 days.

For example, if a recipient is admitted to a hospital, NF or Intermediate Care Facility for the Intellectually Disabled (ICF/IID).

B. After receiving written documentation from the Case Manager (HCBS Waiver Eligibility Form) of the suspension of waiver services, a NOD identifying the effective date and the reason for suspension will be sent to the recipient by the DHCFP LTSS Unit.

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

C. If at the end of the 45 calendar days since admission the recipient has not been removed from suspended status, the case must be closed. The ADSD sends the "HCBS Waiver Eligibility Status Form" to the DHCFP LTSS Unit on or before the 45th day of suspension, identifying the 60th day of suspension as the effective date of termination and the reason for the waiver termination.

D. The DHCFP Unit sends a NOD, to the recipient and/or the designated representative/LRI advising him or her of the date and reason for the waiver closure/termination.

2204.2 RELEASE FROM SUSPENDED WAIVER SERVICES

When a recipient has been released from the hospital or NF before 60 calendar days of the admit date, the Case Manager must do the following within five business days of the recipient's discharge:

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

B. Complete a new POC if there has been a change in services (medical, social or waiver). If a change in services is expected to resolve in less than 30 days, a new POC is not necessary. Documentation of the temporary change must be made in the Case Manager's narrative. The date of resolution must also be documented in the Case Manager's narrative; and

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

2204.3 DENIAL OF WAIVER APPLICATION

Basis of denial for waiver services:

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

B. The applicant does not meet the LOC criteria for NF placement.

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

D. The applicant fails to cooperate with the ADSD or HCBS Waiver service providers in establishing and/or implementing the POC, implementing waiver services or verifying eligibility for waiver services. (The applicant's and/or designated representative/LRI's signature is necessary for all required paperwork.)

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

F. The ADSD has lost contact with the applicant.

G. The applicant fails to show a need for HCBS Waiver services.

H. The applicant would not require NF placement within 30 days or less if HCBS services were not available.

I. The applicant has moved out of state.

J. Another agency or program will provide the services.

K. The ADSD has filled the number of positions (slots) allocated. The applicant has been approved for the waiver wait list and will be contacted when a slot is available.

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

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

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

When the application for waiver services is denied, the ADSD Case Manager sends a "HCBS Waiver Eligibility Status Form" to the DHCFP LTSS Unit. The DHCFP LTSS Unit sends a NOD

to the applicant, letting them know that waiver services have been denied and the reason for the denial.

2204.4 TERMINATION OF WAIVER SERVICES

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

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

B. The recipient no longer meets other eligibility criteria as determined by the DWSS.

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

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

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

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

G. The recipient is no longer at risk of imminent placement in an institution within 30 days or less if waiver services were not available.

H. The recipient has moved out of state.

I. The recipient has signed fraudulent documentation on one or more of the provider time sheets and/or forms.

J. Another agency or program will provide the services.

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

L. The ADSD has lost contact with the recipient.

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

N. The recipient's swallowing ability is not intact and requires skilled service for safe feeding/nutrition. Residential facilities for groups are not licensed to provide skilled services. Recipients with a gastrostomy-tube must be competent and manage their tube

feeding or they are prohibited by HCQC licensure to be admitted into a residential facility for groups.

O. The recipient has been placed in a residential facility for groups that does not have a provider agreement with the DHCFP. Note: The ADSD's Case Manager should work with the provider before terminating the recipient waiver services, explain that all entities providing services must be enrolled as a Medicaid provider and facilitate contact information to the DHCFP's Fiscal Agent.

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

Q. Death of Recipient.

When a recipient is terminated from the waiver, the Case Manager sends the DHCFP LTSS Unit the "HCBS Waiver Eligibility Form" stating the date of termination and the reason(s) for the termination. The DHCFP LTSS Unit sends a NOD to the recipient and/or designated representative/LRI. The NOD must be mailed to the DHCFP, Hearings Unit, at least 13 calendar days before the listed date of action on the form. Refer to MSM, Chapter 3100 Hearings, for specific instructions regarding notice and recipient hearings.

When a termination from waiver services is due to the death of a recipient, the DWSS will terminate the case, and it will notify the ADSD, and the DHCFP of the date of death.

2204.5 REDUCTION OF WAIVER SERVICES

Reasons to reduce services are:

A. The recipient no longer requires the number of service hours/level of service which was previously provided.

B. The recipient no longer requires the service previously provided.

C. The recipient's support system is capable of providing the service.

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

E. The recipient has requested the reduction of services.

F. The recipient's ability to perform ADLs has improved.

G. Another agency or program will provide the service.

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

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

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

2204.6 REAUTHORIZATION WITHIN 90 DAYS OF WAIVER TERMINATION

If a recipient is placed in a NF or hospital and waiver services have been terminated, the recipient may request to be re-instated within 90 days of closure.

2204.6A COVERAGE AND LIMITATIONS

1. The waiver slot must be held for 90 days from the NOD date.

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

   a. They still meet LOC;

   b. There is a slot available;

   c. And is released within 90 days.

3. If the termination took place in a prior waiver year and the recipient still meets a LOC, slot availability and emergent need will be taken into consideration for readmission into the waiver. If 90 calendar days has elapsed from the NOD date, the slot is allocated to the next person on the waitlist.

2204.6B PROVIDER RESPONSIBILITIES

ADSD will ensure appropriate action is taken when re-authorizing a recipient.

2204.6C RECIPIENT RESPONSIBILITIES

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

2205 APPEALS AND HEARINGS

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