

## Minutes

### 1915(i) New Rule Implementation for ADHC

Date: 8/20/15

Time: 2:00pm – 4:00pm

**Chuck Damon:** PowerPoint Presentation

**Cristina Vito (Nevada Adult Day Health Care):** The flow chart is confusing. Would we have to wait for the Universal Needs Assessment and the prior authorization process before setting up a schedule with the recipient?

**Chuck Damon:** It is a concurrent process. The main difference is the new requirement for conflict free case management means the Medicaid Agency will case manage these recipients and ensure that all needs of the recipient are being addressed – and that if additional services are needed the recipient is directed to the appropriate resources.

**Christina Vito:** What does the MCO cover?

**Chuck Damon:** They do not cover ADHC. The process for enrolling an MCO recipient will change.

**Leslie Bittleston:** Currently, the recipient has to be disenrolled from the MCO and become a FFS recipient before receiving ADHC. The procedure will change so that recipients do not have to disenroll from the MCO, and they will receive ADHC services just as the FFS recipients.

**K. Posada (Baby Boomers):** Who makes the determination the recipient is eligible?

**Chuck Damon:** The recipient's physician makes that determination.

**Chris Vito (Nevada Adult Day Health Care):** I understand the need to get all the information and the essential assessments of the recipients, but it already takes 10-14 days to arrange transportation once a plan is in place for services, hopefully the additional assessments and evaluations will happen concurrently so it does not add to the lag between request for services and implementation of services.

I would also like to say that we as a group, the Providers, are pleased about the regulations that a physician cannot refer to an ADHC provider that is essentially his/her office.

**Jennifer Frischmann:** This population was not previously case managed. The addition of case management should eliminate other types of irregular practices as well.

**Jeffrey Klein (Nevada Senior Services): I have a couple of questions.**

What about procedure for clients who move from one State payer source to another?

Currently, all rules are waived for a Medicaid recipient who is a candidate for EPS. How will that change?

Draft MSM 1803.1B Section 4n states the "individual performing the assessment must be an independent third party and must not be: n. service providers or individuals or corporations with financial relationships with the ADHC provider." I am concerned that this could be interpreted too narrowly in cases where there are legitimate relationships with teaching institutions.

**Lynn Hunsinger (Nevada Senior Services):** I have some observations and corrections for the MSM Draft. MSM 1803.1B Part 6 the Plan of Care, change the ADHC provider must develop to must review the Plan of Care. Prior to this, in MSM 1803.1B Part 2a it states than an RN is responsible for conducting a health assessment, that should be changed to participate in conducting the assessment. It should be more clear who has responsibility for the Plan and Care and who is responsible for the Service Plan.

**Leslie Bittleston:** The Service Plan is the types of services needed overall and the Plan of Care contains the details of how and when services are delivered. CMS sometimes uses these terms interchangeably, but they are not the same thing in Nevada. So, in future, the DHCFP will be responsible for the Service Plan and the ADHC Provider will be responsible for the Plan of Care.

**Lynn Hunsinger:** There is the potential of an impact to the provider regarding the recipient's choice of location for the planning meeting. If the recipient requests a meeting in his or her home or somewhere that is not the provider's location, the provider would have to attend and that will cost staff time.

The renewal prior authorization process states the Provider will notify the DHCFP case manager 45 days before the prior authorization end date to being the process. Will the Case Manager also be responsible for keeping track of this date?

**Chuck Damon:** Yes, as it shows on the flowchart, the Case Manager will be responsible for managing their clients. The request to start the renewal process can be instigated from either entity.

To answer Mr. Klein's questions, the first about payer sources – if it is not a Medicaid payer, the process would be whatever that payers normal process is. If it is Medicaid, for example, if leaving waiver, can expedite the process by using the assessments and other forms already completed.

Regarding EPS – that will not change. The safety of the client will always be of paramount importance.

**Christina Vito:** Regarding having an RN on staff, we are having difficulties hiring RNs. They are requesting salaries the providers cannot afford.

**Jennifer Frischmann:** There is a nursing shortage in the state. The Market demand has driven up salaries. The requirement for an RN is set in statute, however.

**Christina Vito:** HCQC told me that it is not their regulation, it is Medicaid's.

**Chuck Damon:** I will look into the HCQC requirements and see if LPN on staff can be considered supervised by an owner who is an RN. I will get back to the group with that information.