MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

November 29, 2022

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: CASEY ANGRES
MANAGER OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 2100 – HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 2100 – HCBS Waiver for Individuals with Intellectual and Developmental Disabilities (ID Waiver) are being proposed to align with the current approved Appendix K to include the addition of Dental Services for ID Waiver recipients ages 21 and over.

Additional proposed changes to this chapter include updating language throughout to match with the Centers for Medicare and Medicaid Services (CMS) settings requirements to fully comply with the HCBS Final Regulation by March 17, 2023.

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: Dentists (Provider Type (PT 22) – all specialties)).

Financial Impact on Local Government: Unknown at this time.

These changes are effective January 1, 2023.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL OL CHAPTER 2100 – HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES	MTL 02/21 CHAPTER 2100 – HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2101	**Authority**	Added 42 CFR 441.301(c)(1) – (c)(5) Federal Person Centered Planning and Settings Requirements. Added NRS 449A.114 (Care of Patients). Added NRS Chapter 631 (Dentistry and Hygiene) for added Dental Services. Added State Plan Amendment (SPA) Attachment 3.1-A Page 5c 12b for added Dental Services. Added SPA Attachment 4.19-B Page 2c for added Dental Services.
2103.1A	**Coverage and Limitations**	Added 'Waitlist Priority' section for clarity~~. and changed from lettering to numbers on priority list.~~
2103.2	**Waiver Services**	Added L. Dental Services as a covered Waiver service.
2103.2A	**Provider Responsibilities**	Updated beginning paragraph to clarify that provider responsibilities listed are for ID Waiver (PT 38) and that specific provider responsibilities for Dentist (PT 22) are listed under MSM Section 2103.14B.
2103.2B	**Recipient Rights and Responsibilities**	Added language indicating recipients must be informed of their rights prior to initiation of waiver services and annually thereafter.
2103.4	**Residential Support Services**	Added language to incorporate the HCBS Final Regulation allowing waiver recipients individual freedom and choice to the same extent as non-Medicaid waiver recipients. To include option for a private room and/or choice of roommate, and options documented in the Primary Care Provider (PCP).
2103.4B	**Provider Responsibilities**	Added language to incorporate the HCBS Final Regulation indicating that providers must make reasonable accommodations to ensure recipients may use and enjoy their dwelling. Added language to incorporate the HCBS Final Regulation indicating that a recipient's lease/other agreement must not differ from non-Medicaid

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		recipients. Recipients must be provided a 30-day written notice before discharging/transferring to another facility and the Service Coordinator must also be notified. Additional language added to indicate the recipient must be allowed 10 days to meet in person after receiving notification of discharge/transfer from a facility. Added language to incorporate the HCBS Final Rule regulation for additional provider responsibilities to ensure the recipient has privacy in their sleeping/living unit, freedom/control of schedules and activities, access to food at any time and able to have visitors of their choosing at any time. Reworded #~~6~~7 for clarity.
2103.6	**Supported Employment**	Added language to incorporate the HCBS Final Regulation allowing Medicaid waiver recipients individual freedom and choice to the same extent as non-Medicaid recipients.
2103.14	**Dental Services**	Created section for new waiver service for dental. Added introduction paragraph indicating the importance of dental health for ID Waiver recipients.
2103.14A	**Coverage and Limitations**	Created new section indicating what specific Dental Services are provided to ID Waiver recipients and that they must be prior authorized.
2103.14B	**Provider Responsibilities**	Created new section outlining specific provider responsibilities for Dental Service providers enrolled as ~~(~~PT 22~~)~~.
2103.14C	**Recipient Responsibilities**	Created new section outlining Recipient Responsibilities specific to Dental Services.
2103.15	**Intake Procedures**	This section was renumbered from 2103.14 to 2103.15. Added language to C. detailing requirements that must be included in the recipient's PCP as outlined in the HCBS Final Rule regulation.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2103.16	**Permanent Case File**	This section was renumbered from 2103.15 to 2103.16.
2103.17	**Service Coordinator Recipient Contacts**	This section was renumbered from 2103.16 to 2103.17.
2103.18	**DHCFP Annual Review**	This section was renumbered from 2103.17 to 2103.18.
2103.19	**Medicaid Provider Enrollment Process**	This section was renumbered from 2103.18 to 2103.19.
2103.20	**Medicaid Enrollment Process**	This section was renumbered from 2103.19 to 2103.20.
2104.3	**Denial of Waiver Application**	Added letter j. denial reason when recipient moves out of state. Added letter k. denial reason when agency has lost contact with the recipient.

2100 INTRODUCTION

~~The~~ Division of Health Care Financing and Policy (DHCFP) and the Aging and Disability Services Division (ADSD) recognizes that many individuals at risk of being placed in Intermediate Care Facilities (ICFs) can be cared for in their homes and communities, preserving their independence and ties to family and friends at a cost no higher than that of institutional care.

The Home and Community Based Services (HCBS) Program for Individuals with Intellectual and Developmental Disabilities (ID Waiver) is an optional service approved by the Centers for Medicare and Medicaid Services (CMS), which authorizes ~~the~~ 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 as well as certain extended Medicaid covered services.

Nevada acknowledges that people who have intellectual and developmental disabilities 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 individuals with intellectual and developmental disabilities with the opportunity to remain in a community setting in lieu of institutionalization.

2101 AUTHORITY

Section 1915(c) of the Social Security Act permits states the option to waive certain Medicaid statutory requirements in order to offer an array of HCBS to eligible individuals who may require such services in order to remain in their communities and avoid institutionalization. ~~The~~ DHCFP's HCBS for Individuals with Intellectual and Developmental Disabilities is approved by the CMS. This waiver is designed to provide eligible Medicaid waiver recipients access to both 1905(a) State Plan services as well as certain extended Medicaid covered services unique to this waiver. The goal is to allow recipients to live in their own homes or community settings.

Statutes and Regulations:

- Social Security Act: 1915 (c)
- Title 42 Code of Federal Regulations (CFR) Section 441, Subpart I (Community Supported Living Arrangements Services)
- Title 42 CFR Section 483.430(a) (Qualified Intellectual Disabilities Professional (QIDP))
- Title 42 CFR Section 441.301(c)(1) - (c)(5) (Federal Person-Centered Planning and Settings Requirements)
- Nevada Revised Statute (NRS) Chapter 435 (Individuals with Intellectual Disabilities and Developmental Disabilities)
- NRS 449A.114 (Care of Patients)
- Nevada Administrative Code (NAC) Chapter 435 (Individuals with Intellectual Disabilities and Developmental Disabilities)
- NAC Chapter 632 (Nursing)
- Health Insurance Portability and Accountability Act (HIPAA)
- Medicaid Service Manual (MSM) Chapter 100
- NRS Chapter 631 (Dentistry and Hygiene)
- State Plan Amendment (SPA) Attachment 3.1-A Page 5c 12b
- SPA Attachment 4.19-B Page 2c

2103 POLICY

2103.1 WAIVER ELIGIBILITY CRITERIA

The HCBS ID Waiver waives certain statutory requirements and offers waiver services to eligible recipients to assist them to remain in the community. The target population for this waiver includes all individuals who are diagnosed with intellectual disabilities or developmental disabilities and who have been found eligible and have an open case with an ADSD Regional Center. Individuals are eligible if they meet Medicaid's eligibility requirements and are either in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or are at risk for ICF/IID placement without the provision of HCBS and supports.

Eligibility for the ID Waiver is determined by the combined efforts of ADSD, ~~the~~ DHCFP and the Division of Welfare and Social Services (DWSS). Two separate determinations must be made to be eligible for and receive services under the ID Waiver:

a. Service eligibility for the ID Waiver is determined by an ADSD's Regional Center.

1. An ADSD Regional Center Intake Team, based on assessments and/or supporting documentation, establishes the existence of an intellectual disability or developmental disability.

2. Each applicant/recipient must meet and maintain Level of Care (LOC) for admission into an ICF/IID. Specifically, the individual would require imminent placement in an ICF/IID facility (within 30 to 60 days) if HCBS Waiver services or other supports were not available.

3. Each applicant/recipient must demonstrate a continued need for a waiver service(s) to prevent placement in an ICF/IID. Sole utilization of Medicaid State Plan Services does not support the qualifications to be covered by the waiver.

4. The applicant/recipient must have a support system 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 services are not being provided. HCBS Waiver services are not a substitute for available natural and informal supports provided by family, friends or other available community resources.

b. The financial eligibility determination for Medicaid benefits is made by ~~the~~ DWSS. Waiver applicants/recipients must meet and maintain Medicaid eligibility coverage for all months in which waiver services are provided.

c. Services from the ID Waiver cannot be provided until and unless the applicant is found eligible in both determination areas.

2103.1A COVERAGE AND LIMITATIONS

1. Waiver recipients must meet and maintain Medicaid's eligibility coverage through the DWSS for all months waiver services are being provided.

2. The ID Waiver is limited by legislative mandate and available matching state funding to a specific number of recipients who can be served throughout the biennium. A waitlist is utilized to prioritize applicants who have been presumed to be eligible for the waiver as defined below.

~~2.~~3. Waitlist Priority

a. ~~First priority is i~~Individuals residing in an ICF/IID or other institutional settings.

b. ~~Second priority is i~~Individuals who are at risk of institutionalization due to loss of their current support system or crisis situation.

c. ~~Third priority is all i~~Individuals, deemed appropriate for waiver services, who do not fall under priority one or two, based on the date of request for a waiver service.

~~3.~~4. ~~The~~ DHCFP must assure the CMS that Medicaid's total expenditures for waiver and Medicaid State Plan services will not, in any waiver year, exceed 100% of the amount that would be incurred by Medicaid for these individuals in an institutional setting in the absence of the waiver. ~~The~~ DHCFP must also document that there are safeguards in place to protect the health and welfare of recipients.

~~4.~~5. Waiver services must not be billed when an individual is admitted to an institutional setting, such as a hospital, ICF/IID or nursing facility (NF) for the duration of the stay. Residential settings that bill per diem may bill the per diem rate for admit and discharge days only when services were provided and documented for some part of the days in question. Residential settings that bill by the unit or hour may bill for services provided and documented on admit and discharge days.

Section 3715 of the CARES Act may be utilized where HCBS can be provided in an acute care hospital setting ~~as long as~~ if those services are:

a. ~~i~~Identified in an individual's person-centered support plan (or comparable Plan of Care (POC));

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

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

~~5.~~6. If an applicant/recipient is determined eligible for more than one HCBS Waiver, the individual cannot receive services under two or more such 1915(c) waivers at the same time. The applicant/recipient must choose one HCBS Waiver and receive services provided by that waiver.

~~6.~~7. Recipients of the ID 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. Collaborative case coordination between the hospice agency and the waiver Service Coordinator is required to prevent any duplication of services. Refer to MSM Chapter 3200 for additional information on hospice services.

~~7.~~8. An able and/or capable parent, spouse or Legally Responsible Individual (LRI) of a recipient has a duty/obligation to provide the necessary maintenance, education, supervision and support. Necessary maintenance includes but is not limited to, the provision of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). Payment will not be made for the routine care, supervision or services normally provided for the recipient without charge as a matter of course in the usual relationship among members of the nuclear family. Waiver services are not a substitute for available natural and informal supports provided by family, friends or other available community resources; however, they are available to supplement those support systems, so the recipient is able to remain in their home.

Allowance may be given in individual circumstances when:

a. ~~t~~There is no LRI residing in the recipient's home; or

b. ~~or t~~There is no other LRI residing in the home and an able and/or capable spouse/parent's employment requirements result in prolonged or unexpected absences from the home; or

c. ~~or w~~When such employment requirements require the able and/or capable spouse/parent or LRI to work uninterrupted at home in order to meet the requirement of his or her employer; or

d. ~~or w~~When employment requirements include unconventional work weeks or work hours; or

e. ~~or t~~The recipient's support team has documented a need for ADL or IADL habilitative services to be provided by direct support staff.

The LRI may be asked to provide verification from a physician, place of employment, or school that they are not capable, due to illness or injury, or unavailable, due to hours of employment and school attendance, to provide services. Additional verification may be required on a case by case basis.

~~8.~~9. LRIs may not be reimbursed for HCBS Waiver services.

~~9.~~10. Legal guardians of individuals age 18 and over are considered LRIs.

~~10.~~11. The children made eligible for Medicaid through their enrollment in the Waiver for Individuals with Intellectual and Developmental Disabilities receive all the medically necessary Medicaid coverable services available under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). A child's enrollment in the waiver will not be used to deny, delay, or limit access to medically necessary services that are required to be available to Medicaid-eligible children under federal EPSDT rules. The waiver service package is a supplement to EPSDT services.

2103.1B PROVIDER RESPONSIBLITIES

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

2103.1C RECIPIENT RESPONSIBLITIES

Applicants or recipients must meet and maintain all criteria to be eligible, and to remain on the ID Waiver.

2103.2 WAIVER SERVICES

~~The~~ ADSD, the operating agency for the ID waiver, in conjunction with the DHCFP, the administrating agency determines which services will be offered under the ID Waiver.

Under this waiver, the following services are available:

A. Day Habilitation.

B. Residential Support Services.

C. Prevocational Services~~.~~

D. Supported Employment.

E. Behavioral Consultation, Training and Intervention

F. Counseling Services~~.~~

G. Residential Support Management~~.~~

H. Non-Medical Transportation~~.~~

I. Nursing Services~~.~~

J. Nutrition Counseling Services~~.~~

K. Career Planning~~.~~

L. Dental Services

2103.2A PROVIDER RESPONSIBILITIES

For Provider Type (PT) 22, refer to Section 2103.14B for details, and the Provider Enrollment Checklist at https://www.medicaid.nv.gov/providers/checklist.aspx.

For PT 38:

1. Provider Requirements:

a. Must obtain approval or certification, as applicable, from ADSD/Developmental Services (DS) pursuant to Nevada Revised Statute (NRS) 435, Nevada Administrative Code (NAC) 435 and ~~the~~ ADSD Policy and Procedures.

b. Must obtain a Master Service Agreement through Department of Administration Purchasing Division and a Provider Service Agreement through ~~the~~ ADSD.

c. Must enroll as a ~~Provider Type~~PT 38 with Fee-for-Service Nevada Medicaid, meet and maintain all the requirements to be enrolled as a Medicaid provider pursuant to MSM Chapter 100 and 2100.

d. May not bill for services provided by an LRI.

e. May only provide and bill for services that have been authorized in the PCP. Prior authorization for waiver services is made through the recipient's PCP and Service Authorization.

f. Must verify the Medicaid eligibility status of each HCBS Waiver recipient each month.

g. Upon renewal of professional licenses/certifications, providers must submit copies of renewals to ~~the~~ ADSD as applicable.

~~g.~~

h. Each provider must cooperate with ~~the~~ ADSD, ~~the~~ DHCFP and/or State or Federal reviews or inspections.

i. Must have the ability to communicate with the recipient, understand the recipient and implement the recipient's PCP.

2. Criminal Background Checks:

A criminal background check is required for all owners, administrators, subcontractors, volunteers and employees who have contact with recipients or access to their financial or personal information.

Refer to MSM Chapter 100 for provider requirements.

All background check information must be maintained on file and available for review, including the initial check and a recheck for each five (5) year period. Refer to NRS 435.220, 435.333, 435.537 and 435.893, NAC 435.515, 435.518, 435.520, 435.537, 435.845, 435.855, 435.860 and 435.893.

3. Required Training for Providers:

a. Employees must have Cardio Pulmonary Resuscitation (CPR) and First Aid training within 30 days of hire and prior to working alone with recipients, if providing direct service. Documentation of training must be kept on file and available for review.

b. Must complete required training and new employee orientation, per ADSD policy, within six months of beginning employment. Documentation of training to be kept on file and available for review.

c. All providers are required to provide annual training to employees on recipient rights; confidentiality; abuse, neglect, exploitation, isolation and abandonment including definitions, signs, symptoms, and prevention; as well as incident and

serious occurrence reporting requirements. Providers will also complete established training requirements as directed by ~~the~~ ADSD. Documentation of training must be kept on file and available for review.

d. Supported Living provider employees who administer medication must maintain current certification for Medication Administration pursuant to NAC 435.675. Documentation of training must be kept on file and available for review.

e. Any employee who is likely to utilize restraint procedures in accordance with NRS 433 must maintain current certification in a Crisis Prevention/Intervention training program approved by ~~the~~ ADSD. Approved training programs require national recognition and evidence of annual review and update of curriculum based on the best legal, behavioral and ethical practices of standards of care. Documentation of training must be kept on file and available for review.

4. Exemptions from Training

a. ~~The~~ ADSD~~,~~ 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.

b. The exemption and its rationale must be provided in writing and a copy of the exemption must be placed in the recipient's case record. Where the recipient or other private ~~third party~~third-party functions as the employer, such individuals may exercise the exemption authority identified above.

5. Documentation:

Providers must maintain relevant documentation of services provided on one or more documents, including documents that may be created or maintained in electronic format. This documentation must be kept in a manner as to fully disclose the nature and extent of services delivered and must be readily available for review.

The documentation must include:

a. Type of service.

b. Date of service.

c. Name of recipient receiving service.

d. Recipient record number.

e. Name of provider.

f. Full written or electronic signature or initials of the person delivering the service if a signature and corresponding initials are on file with the provider. For electronic signatures, systems and software products must include protections against modification, with administrative safeguards that correspond to policies and procedures of the operating agency. 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. For example, an attendance record must have daily initials and documentation of time in and time out.

g. Number of units of the delivered service during which time the service was provided.

h. Signatures or initials of the recipient must be included on the Jobs and Day Training (JDT) and Residential Support Services logs. If the recipient is unable to provide initials due to a cognitive and/or physical limitation, this will be clearly documented in the Person Centered Plan (PCP).

i. Recipient's living in 24 hour Residential Support settings must have individualized service logs, even if they have shared support hours with roommates living in the home.

j. Providers are required to have copies of side effect information sheets for all medications taken by the recipient on-hand and available for staff.

6. Incidents and Serious Occurrences:

Each Provider must report any recipient incidents to ~~the~~ ADSD. Serious occurrences are to be reported to ~~the~~ ADSD within 24 hours. All other reportable incidents are to be reported to ~~the~~ ADSD within two business days. All Serious Occurrence Reports must be maintained on file by the provider. ~~The~~ ADSD will submit quarterly data to ~~the~~ DHCFP for serious occurrence reports.

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

a. Unplanned hospitalization or ER visit;

b. Injury or fall requiring medical intervention;

c. Physical, verbal, emotional, sexual abuse or sexual harassment;

d. Assault, violence, or threat;

e. Suicide threat or attempt;

f. Criminal activity or legal involvement;

g. Theft or exploitation;

h. Medication error per ~~the~~ ADSD policy;

i. Loss of contact with the recipient;

j. Elopement of a recipient residing in a 24-hour setting;

k. Death of the recipient; or

l. HIPAA violation;

m. Major property damage;

n. Auto accident (involving the recipient);

o. Staff injury/illness/accident requiring medical attention;

p. Environmental incident requiring emergency assistance

q. Death of unpaid caregiver.

7. Notification of Suspected Abuse, Neglect, Exploitation, Isolation, or Abandonment:

State law requires that individuals employed in certain capacities must make a report to the appropriate law enforcement or applicable reporting agency immediately, but in no event later than 24 hours after there is reason to suspect the abuse, neglect, exploitation, isolation, or abandonment of a minor child, vulnerable adult or older individual. DHCFP requires that all providers be in compliance with the intent of all applicable laws.

For recipients under the age of 18, the Division of Child and Family Services (DCFS) or the appropriate county agency accepts reports of suspected child abuse and neglect. For vulnerable adults' age 18 and over, or any adult 60 or over, Adult Protective Services within ADSD accepts reports of suspected abuse, neglect or self-neglect, exploitation or isolation.

a. Child Abuse - Refer to NRS 432B regarding child abuse or neglect.

b. Abuse of a Vulnerable Adult or Oder Person- Refer to NRS 200.5091 to 200.50995 regarding elder abuse, exploitation, isolation neglect or abandonment.

c. Vulnerable adult (NRS 200.5091 to 200.50995) is defined as "a person 18 years of age or older who:"

1. ~~1. s~~Suffers from a condition of physical or mental incapacitation because of a developmental disability, organic brain damage or mental illness; or

2. ~~h~~Has one or more physical or mental limitations that restrict the ability of the person to perform the normal ADLs.

8. Complaint Procedure

The Provider must respond to all complaints in a reasonable and prompt manner. The Provider must maintain records that identify the complaint, the date received and the response, outcome and resolution of the incident.

The Provider must investigate and respond in writing to all written complaints within ten calendar days of receipt.

The Provider will provide the recipient written notification of the complaint and its outcome. As appropriate, written notification must also be provided to the Regional Center Service Coordinator.

9. HIPAA, Privacy, and Confidentiality

Refer to MSM Chapter 100 for information on HIPAA, privacy, and confidentiality of recipient records and other Protected Health Information (PHI).

10. ~~The~~ ADSD:

An Interlocal Agreement between ~~the~~ ADSD and ~~the~~ DHCFP is maintained to outline responsibilities of both agencies in the operation and administration of ~~the~~ HCBS for the ID Waiver.

11. Provider Agencies:

a. All employees must have a file which includes reference checks, CPR/First Aid certification and documentation of new employee orientation and ongoing training. All background check information must be maintained in a separate individual employee file~~.~~

2103.2B RECIPIENT RIGHTS AND RESPONSIBILITIES

The Recipients are entitled to their privacy; to be treated with respect; and be free from coercion and restraint. Recipients are informed of their rights prior to initiation of services and annually thereafter.

~~Additionally~~Additionally, applicants or recipients must meet and maintain all criteria to be eligible and to remain on the ID Waiver.

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

1. Notify the provider(s) and Service Coordinator of a change in Medicaid eligibility.
2. Notify the provider(s) and Service Coordinator of current insurance information, including the name of other insurance coverage, such as Medicare.
3. Notify the provider(s) and Service Coordinator of changes in medical status, service needs, address, and location, or changes of designated representative/LRI.
4. Treat all staff and providers appropriately with respect and in a safe manner.
5. Initial and/or sign the provider service documentation logs as applicable, verifying services were rendered unless otherwise unable to perform this task due to intellectual and/or physical limitations.
6. Notify the provider when scheduled visits cannot be kept.
7. Notify the provider and Service Coordinator of missed visits by provider staff.
8. Notify ~~the~~ ADSD and the provider if services are no longer requested or required.
9. Notify the provider and ~~the~~ ADSD Service Coordinator of unusual occurrences, complaints regarding delivery of services or specific staff, or to request a change in caregiver.
10. If applicable, furnish the provider with a copy of their Advance Directives (AD).
11. Not request a provider to work more than the hours authorized in the PCP.
12. Not request a provider to provide service for a non-recipient, family, or household members.
13. Not request a provider to perform services not included in the PCP.
14. Contact the Service Coordinator to request a change of provider.

2103.3C RECIPIENT RIGHTS AND RESPONSIBILITIES

Refer to MSM Section 2103.2B.

2103.4 RESIDENTIAL SUPPORT SERVICES

Residential Support Services are designed to ensure the health and welfare of the recipient, as well as the welfare of the community at large, through protective oversight and supervision activities in addition to support to assist in the acquisition, improvement, retention, and maintenance of the skills necessary for recipients to reside in their community successfully, safely, and responsibly. ~~reside in their community~~.

Residential Support Services are provided throughout the course of normal ADLs, as well as in specialized training opportunities outlined in the recipient's PCP. These services are individually planned and coordinated, assuring the non-duplication of services with other Medicaid State Plan Services. PCP teams may identify priority areas to address through habilitation plans, however that does not limit additional supports that a person may need to live in the community. These additional supports do not require habilitation plans.

Residential Support Services staff are trained and responsible for implementing the Individual Habilitation Plans, goals and objectives, and other service supports related to residential and community living. These supports include but are not limited to:

A. ~~t~~The facilitation of personal care;

B. ADLs and IADLs;

C. S~~s~~upports for health and welfare needs;

D. ~~e~~Effective communication skills;

E. ~~c~~Community inclusion;

F. ~~t~~The development of natural support networks;

G. ~~m~~Mobility training;

H. ~~s~~Survival and safety skills;

I. ~~s~~Support and teaching of interpersonal and relationship skills;

J. ~~m~~Making choices and problem-solving skills;

K. ~~c~~Community living skills;

L. ~~s~~Social and leisure skills;

M. ~~m~~Money management skills and;

N. ~~s~~Support and skill training related to health care needs, to include medication management.

Residential Support Services emphasize positive behavioral strategies, including interventions and supervision designed to maximize community inclusion while safeguarding the recipient and general public. The Service Coordinator will ensure the recipient has freedom in their residential setting. Services also support exercising recipient's rights and protect against rights violations and infringements without due process.

Intermittent Supported Living Services are services provided by an individual or organizational provider to recipients residing in their own homes who do not require one-on-one supervision and/or 24-hour care.

A Shared Living Arrangement is an arrangement in which an individual with a disability, and a person, couple or family choose to live together in an integrated community neighborhood which provides Residential Support Services through an intermittent Supported Living Arrangement (SLA).

Twenty-four hour Supported Living Services are Residential Support Services provided up to 24 hours per day by an organizational provider. These services are delivered within homes in integrated neighborhood settings.

Residential Support Services cannot duplicate the scope and nature of Medicaid State Plan Personal Care Services (PCS). Services must be coordinated to ensure there is no duplication. Waiver services must be authorized in the recipient's PCP.

The setting is selected by the individual from among setting options including non-disability specific settings, and an option for a private unit in a residential setting. The setting options are identified and documented in the PCP and are based on the individual's needs and preferences, including choice of roommates as applicable.

2103.4A COVERAGE AND LIMITATIONS

1. Residential Support Services staff receives training and are responsible for implementing PCPs, goals, objectives, and service supports related to residential living and community life.

   These services include but are not limited to:

a. ~~t~~The participation in the development of the PCP.

b. ~~a~~Adaptive skill development.

c. ~~f~~Facilitation of personal care and ADLs.

d. ~~f~~Facilitation of community inclusion.

e. ~~f~~Facilitation of IADLs to include teaching community life skills; interpersonal and relationship skills; building of natural support networks; choice making skills; social and leisure skills; budgeting and money management skills.

f. ~~p~~Providing assistance with medication administration by a staff certified in an ADSD approved Medication Program. Verification of certification must be maintained in the employee files.

g. ~~p~~Providing assistance with support and skill training in health care needs.

h. ~~f~~Facilitation of mobility training, survival and safety skills.

2. Residential Support Services may be provided on a continuum of service delivery model ranging from intermittent up to 24-hour SLA, as determined by the PCP team. Residential Support Services are provided in either the service recipient's natural family home or in a non-provider owned home or apartment; owned or leased in the service recipient's name or on behalf of the service recipient, with the exception of approved Shared Living services and provider owned homes that have been approved by the Regional Center. The provider is required to have a lease with each service recipient living in a provider owned home. Residential Support Services are provided in integrated settings within community residential neighborhoods. In 24-hour SLA, protective oversight hours must be shared with other recipients in the home unless clear documentation exists that shows a need for one-on-one supervision due to health and safety needs of the recipient which are supported in the PCP and approved by the Regional Center Program Manager.

3. Under this service category, the responsibility for the living environment rests with the service agency and encompasses a variety of SLAs:

a. Residential Support Services in a 24-hour setting are limited to four recipients unless otherwise authorized by the Regional Center Program Manager.

b. SLAs are limited to two service recipients residing in one home, unless otherwise authorized by the Regional Center Program Manager.

Individual SLA homes do not require state licensure; however, individual providers and provider agencies must be certified by ~~the~~ ADSD in order to render services to ID Waiver recipients.

2103.4B PROVIDER RESPONSIBILITIES

Refer to MSM 2103.2A, in addition to the provider responsibilities listed:

1. Providers must ensure the recipient has the freedom to furnish and decorate their sleeping or living units. The provider may make reasonable accommodations in rules, policies, practices, or services if those accommodations are necessary to ensure that the person with the disability may use and enjoy the dwelling. If accommodations cannot be met due to behavioral reason, medical condition etc., it must be documented and justified in the person-centered service plan.~~living area to their liking within the lease or other agreement.~~

2. The recipient's lease or other agreement must not differ from those individuals who do not receive Medicaid HCBS and must include:

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

   b. Provide the recipient and Service Coordinator with written notice of the intent to transfer or discharge the recipient; and

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

3. The Provider will ensure the setting is physically accessible to the recipient. The Provider will ensure the units have entrance doors lockable by the individual, with only appropriate staff having keys to doors. The provider will ensure each recipient has privacy in their sleeping or living unit.

4. The provider will ensure recipients have the freedom and support to control their own schedules and activities and have access to food at any time.

5. The provider will ensure that recipients are able to have visitors and associate with people of their choosing at any time.

6. ~~3.~~ ~~For S~~settings where landlord/tenant laws do not apply, the provider must ensure that a written residential agreement is in place for the HCBS Waiver recipient and that it provides comparable protections as those under the jurisdiction's landlord/tenant law.

7. Exceptions to any of the above requirements must be supported by assessed need and clearly justified and documented in the PCP.

2103.4C RECIPIENT RIGHTS AND RESPONSIBILITIES

Refer to MSM 2103.2B.

2103.5 PREVOCATIONAL SERVICES

Prevocational Services should enable recipients to attain the highest level of vocation in the most integrated setting and by matching the recipient's interests, strengths, priorities, abilities, and capabilities to the job while following applicable Federal wage guidelines. The services are intended to develop and teach general skills. Examples include but are not limited to: ability to communicate with supervisors, co-workers and customers in the workplace setting; generally accepted workplace conduct and dress; an ability to follow directions; an ability to complete tasks; workplace problem solving skills and strategies; and workplace safety and mobility training.

Prevocational Services provides for learning and work experience, which may include volunteer work, where a recipient can develop general, non-job or task-specific strengths and skills that contribute to employability in paid employment within integrated community settings. Services are expected to occur over a defined period of time and with specific outcomes to be achieved, as identified in the recipient PCP. The services are designed to create a path to integrated, community-based employment for which a recipient is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Recipients receiving Prevocational Services must have employment-related goals in their PCP; the general habilitative activities must be designed to support such employment goals Competitive, integrated employment in the community for which a recipient is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities, considered to be the optimal outcome for Prevocational Services.

2103.5A COVERAGE AND LIMITATIONS

The Prevocational Services provided under this waiver are not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or Section 602(16) and (17) of the IDEA (20

U.S.C. 1401(16 and 17)). Documentation will be maintained in the file of each recipient receiving Prevocational Services that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

1. Recipients who receive Prevocational Services may include two or more types of non-residential support services; however, different types of non-residential support services may not be billed during the same time period of the day.

2103.5B PROVIDER RESPONSIBILITIES

Refer to MSM Section 2103.2A.

2103.5C RECIPIENT RIGHTS AND RESPONSIBILITIES

Refer to MSM Section 2103.2B.

2103.6 SUPPORTED EMPLOYMENT

Supported Employment Services are individualized and may include any combination of the following services: Vocational job related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, benefit supports, training and planning, transportation training, asset development and career advancement services and other workplace support services including services not specifically related to job skill training that enable the recipient to be successful in integrating into the job setting.

The setting is integrated in and supports full access of individuals receiving services to the greater community, including opportunities to seek employment and work in competitive integrated settings, and engage in community life. The setting is selected by the individual from among setting options including non-disability specific settings. The service optimizes but does not regiment individual initiative, autonomy, and independence in making life choice including but not limited to, daily activities, physical environment and with whom to interact. Individuals have the freedom and support to control their own schedules and activities and have access to food at any time within the parameters of their employment. Individuals are able to have visitors and associate with people of their choosing as applicable to their employment policy. The setting is physically accessible to the individual.

There are two sub-categories of Supported Employment – Individual Supported Employment and Small Group Supported Employment.

1. Individual Supported Employment

Behavioral Consultation, Training and Intervention Services provide behaviorally based assessment and intervention for recipients, as well as support, training, and consultation to family members, caregivers, paid residential support staff, or jobs and day training staff. This service also includes participation in the development and implementation of the PCP and/or Positive Behavior Support Plans, necessary to improve a recipient's independence and inclusion in their community, increase positive alternative behaviors, and/or address challenging behavior. These services are not covered under the State Plan and are provided by professionals in Psychology, Behavior Analysis and related fields.

2103.7A COVERAGE AND LIMITATIONS

1. Behavioral Consultation, Training and Intervention may be provided in the recipient's home, school, workplace, and in the community. The services include:

   a. ~~f~~Functional behavioral assessment and an assessment of the environmental factors that are precipitating a problem behavior;

   b. ~~d~~Development of Behavior Support Plan in coordination with the team members;

   c. ~~c~~Consultation and/or training on how to implement positive behavior support strategies and/or Behavior Support Plan;

   d. ~~c~~Consultation or training on data collection strategies to monitor progress;

   e. ~~m~~Monitoring of recipient and the provider(s) in the implementation and modification of the support plan, as necessary;

   f. Participation in the PCP;

   g. Team meeting and medical appointments to provide resources information and recommendations, as necessary; and

   h. Providing a monthly summary of progress.

Behavioral Consultation, Training and Intervention may not exceed $5,200.00 per year per recipient. Written authorization by the Regional Center is required for amounts in excess of the limit.

2103.7B PROVIDER RESPONSIBILITIES AND QUALIFICATIONS

~~1.~~ In addition to the provider responsibilities listed in MSM Section 2103.2A:

1. Employees of behavioral provider agencies and individual providers have:

a. Professional holding Bachelor's level licensure and/or certification per NRS 437; or has a Bachelor's degree in psychology, special education or closely related field plus at least one year professional clinical experience using behavior intervention and functional assessment procedures as well as developing, implementing and monitoring of behavior support plans in applied setting; or

~~a.~~

b. Professional holding Master's level licensure and/or certification per NRS 437; or has a Master's degree in psychology, special education or closely related field with expertise in functional assessment and the provision of positive behavioral supports.

~~1.~~2. Experience working with individuals with intellectual disabilities or developmental disabilities is preferred.

2103.7C RECIPIENT RIGHTS AND RESPONSIBILITIES

Refer to MSM Section 2103.2B.

2103.8 COUNSELING SERVICES

Counseling Services provide assessment/evaluation, consultation, therapeutic interventions, support and guidance for recipients and/or family members, caregivers, and team members, which are not covered by the Medicaid State Plan and which improve the recipient's personal adaptation and inclusion in the community. This service is available to recipients who have intellectual and/or developmental disabilities and provides problem identification and resolution in areas of interpersonal relationships, community participation, independence, and attaining personal outcomes, as identified in the recipient's PCP.

Counseling Services are specialized and adapted in order to accommodate the unique complexities of enrolled recipients and may include:

A. ~~c~~Consultation with team members, including family members, support staff, service coordinators and other professionals comprising the participant's support team;

B. ~~i~~Individual and group counseling services;

C. ~~a~~Assessment/evaluation services;

D. ~~t~~Therapeutic interventions strategies;

E. ~~r~~Risk assessment;

F. ~~s~~Skill development;

G. ~~p~~Psycho educational activities;

H. ~~p~~Participating in PCP Team meetings and appointments to provide resource information and recommendations, as necessary; and

I. ~~p~~Providing a monthly summary of progress.

Counseling services are provided based on the recipient's need to assure his or her health and welfare in the community and enhance success in community living.

2103.8A COVERAGE AND LIMITATIONS

Counseling services may not exceed $1,500.00 per year per recipient. Written authorization by the Regional Center is required for amounts in excess of the limit.

2103.8B PROVIDER RESPONSIBILITIES AND QUALIFICATIONS

~~1.~~ In addition to the provider responsibilities listed in MSM Section 2103.2A:

1. ~~a.~~ Providers must have graduated from an accredited college or university with a Master's degree in a two year curriculum in counseling, marriage and family therapy, psychology, social work or a closely related academic field. A closely related field is licensed by the State of Nevada by appropriate categories; or

2. ~~b.~~ A graduate level intern who is enrolled in a Master's level program at an accredited college or university that provides at least two year curriculum in counseling, marriage and family therapy, psychology, social work or a closely related academic field or doctor level program in a clinical field; and are supervised by a licensed clinician or mental health counselor.

~~2.~~3. Professional experience in a setting serving individuals with intellectual disabilities is preferred.

2103.8C RECIPIENT RIGHTS AND RESPONSIBILITIES

Refer to MSM Section 2103.2B.

2103.9 RESIDENTIAL SUPPORT MANAGEMENT

Residential Support Management is designed to ensure the health and welfare of recipients receiving Residential Support Services from agencies. This service is intended to ensure the supports are planned, scheduled, monitored, and implemented according to the recipient's preferences and needs depending on the frequency and duration of approved services.

2103.9A COVERAGE AND LIMITATIONS

1. Residential Support Management staff will assist the recipient in managing their supports within the home and community settings. This service includes:

   a. ~~a~~Assisting the recipient to develop one's goal(s);

   ~~2.~~4.~~s~~Scheduling and attending interdisciplinary meetings;

   ~~3.~~5.~~d~~Develop habilitation plans specific to Residential Support Services, as determined in the recipient's PCP and training residential support staff in implementation and data collection;

   d. ~~a~~Assisting the recipient to apply for and obtain community resources and benefits such as Medicaid, Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Housing and Urban Development (HUD), Supplemental Nutrition Assistance Program (SNAP), housing, etc.;

   e. ~~a~~Assisting the recipient in locating residences;

   f. ~~a~~Assisting the recipient in arranging for and effectively managing community resources and informal supports;

   g. ~~a~~Assisting the recipient to identify and sustain a personal support network of family, friends, and associates;

   h. ~~p~~Providing problem solving and support with crisis management;

   i. ~~s~~Supporting the recipient with budgeting, bill paying, and with scheduling and keeping appointments;

   j. ~~o~~Observing, coaching, training and providing feedback to direct service staff to ensure they have the necessary and adequate training to carry out the supports and services identified in the PCP;

   k. ~~f~~Following up with health and welfare concerns and remediation of deficiencies;

l. ~~c~~Completing required paperwork on behalf of the recipient (as needed);

m. ~~m~~Making home visits to observe the recipient's living environment to assure health and welfare; and

n. ~~p~~Providing information to the Service Coordinator (Targeted Case Manager) and support team members to allow evaluation and assurance that support services provided are those defined in the PCP and are effective in assisting the recipient to reach his or her goals.

2. Residential Support Managers must work collaboratively with the recipient's Service Coordinator as well as other support team members. Residential Support Management services are different from Targeted Case Management as the Service Coordinator is responsible for the development of the PCP, which is the overall HCBS support plan, in consultation with the PCP Team.

2103.9B PROVIDER RESPONSIBILITIES AND QUALIFICATIONS

In addition to provider listed in 2103.2A, Residential Support Managers must have:

1. A High School Diploma or equivalent and two years' experience providing direct service in a human services field and remain under the direct supervision/oversight of a Qualified Intellectual Disabilities Professional (QIDP) or its equivalent; or

2. Completion of a Bachelor's degree from an accredited college or university in psychology, special education, counseling, social work, or closely related field and one year of experience meeting the qualification of a QIDP.

2103.9C RECIPIENT RIGHTS AND RESPONSIBILITIES

Refer to MSM Section 2103.2B.

2103.10 NON-MEDICAL TRANSPORTATION

Non-Medical Transportation service are offered to enable recipients to gain access to community activities. Non-Medical Transportation service allows recipients to engage in normal day-to-day non-medical activities such as going to the grocery store or bank, participating in social and recreational events or attending a worship service; activities are not all inclusive. Whenever possible, family, neighbors, friends, or community agencies should provide this service without charge.

2103.10A COVERAGE AND LIMITATIONS

1. This service will not duplicate or impact the amount, duration and scope of the Medical Transportation benefit provided under the Medicaid State Plan. Refer to MSM Chapter 1900 for more information regarding the coverage and limitations of State Plan Medical Transportation.

2. Non-Medical Transportation services under this waiver must be described or identified in the recipient's PCP before the service is utilized. The use of Non-Medical Transportation must be summarized in the provider's quarterly progress report.

3. Non-Medical Transportation fees cannot exceed $100.00 per month per recipient.

2103.10B PROVIDER RESPONSIBILITIES

In addition to provider responsibilities listed in 2103.2A, providers must have:

1. A valid Nevada Driver's License and provide verification of safe driving record and proof of driver's liability insurance.

2. Evidence of vehicle safety inspection completed prior to transporting recipient's and completion of ongoing periodic vehicle safety inspections. Providers are responsible for obtaining vehicle safety inspections and providing them to ~~the~~ ADSD upon request.

2103.10C RECIPIENT RIGHTS AND RESPONSIBILITIES

Refer to MSM Section 2103.2B.

2103.11 NURSING SERVICES

There are three components of Nursing Services: Medical Management, Nursing Assessment, and Direct Services, (over and above State Plan).

1. Medical Management

These services will be provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) licensed in the state. Services are geared toward the development of health services support plans; training of direct support staff or family members to carry out treatment; monitoring of staff knowledge and competence to improve health outcomes; assistance with revision of health support plans in response to new or revised treatment orders or lack of positive outcomes of current supports by staff; monitoring/ assessment of the recipient's condition in response to current health supports provided; and as needed assistance with referrals to other medical providers. This service includes professional observation and assessment, individualized program design and implementation, training of recipients and

a waiver recipient is receiving Pre-Vocational Services or Day Habilitation Services, Career Planning may be used to develop additional learning opportunities and career options consistent with the recipient's skills and interest.

2. Career Planning will be limited to 216 hours within a six-month time period each year per recipient. The six-month periods may not be provided consecutively.

3. Career Planning furnished under the waiver may not include services available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401 (16 and 17).

2103.13B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in MSM Section 2103.2A, providers of Career Planning must have:

1. Experience in working with individuals with intellectual and developmental disabilities providing employment service and job development.

2. Knowledge of person-centered career planning, job analysis, supported employment services, situational and community-based assessments, best practices in customized employment, and knowledge of the business needs of an employer.

3. A Valid Nevada Driver's License. Must also have access to an operational and insured vehicle and be willing to use it to transport recipients. (Providers will bill Career Planning unit rate for time spent transporting, this is not a separate rate); And

4. Evidence of vehicle safety inspection completed prior to transporting recipient's and completion of ongoing periodic vehicle safety inspections. Providers are responsible for obtaining safety inspections and providing them to the ADSD upon request.

2103.13C RECIPIENT RIGHTS AND RESPONSIBILITIES

Refer to MSM Section 2103.2B.

2103.14 DENTAL SERVICES

Oral health has a direct impact on the ID Waiver recipient's overall health and quality of life. Adults with Intellectual or Developmental Disability (IDD) often have specific challenges during treatment such as the need for behavioral modifications.

2103.14A COVERAGE AND LIMITATIONS

1. The dental services under this waiver are only provided for individuals age 21 and over. All Medicaid medically necessary dental services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

2. Dental services include but are not limited to:

   a. Restoration (e.g. amalgam filling, resin-based composite filling, prefabricated stainless steel crown and resin-crown, core buildup, etc.); and

   b. Preventative care such as regular check-ups, cleaning, fluoride treatments, x-rays, fillings, periodontal maintenance, periodontal scaling and root planning and root canal therapy.

   c. For a complete list of covered dental services for ID Waiver recipients age 21 and over refer to https://www.medicaid.nv.gov in the (PT 22) Billing Guide.

   NOTE: The scope and nature of this service differs from the State Plan Dental Service for Adults, which only offers emergency extractions, palliative care, and removable prosthesis with prior authorization.

3. Dental services do not include extractions for cosmetic purposes.

4. Dental services exceeding program limitations are not considered Medicaid benefits and are the financial responsibility of the recipient.

5. Dental services must be prior authorized before rendering services.

2103.14B PROVIDER RESPONSIBILITIES

1. Provider requirements for PT 22:

   a. Dental providers must be licensed by the Nevada State Board of Dental Examiners.

   b. Must maintain a Medicaid Services Provider Agreement and comply with the criteria set forth in the Nevada Medicaid Services Manual Chapter 100 and MSM Chapter2100.

   c. Dentists, public health endorsed dental hygienists and dental therapists enrolled with Nevada Medicaid can bill for services provided to eligible ID Waiver recipients.

2. Reference Nevada Medicaid's Dental Benefit Schedule (Attachment A of the "PT 22" Billing Guide) document located at https://www.medicaid.nv.gov in Dentist (PT 22) Billing Guide for a list of Current Dental Terminology (CDT) codes detailing prior authorization requirements and service limitations.

3. Request for Prior Authorization must be submitted electronically to the DHCFP fiscal agent website at https://www.medicaid.nv.gov before rendering dental services.

4. Providers must verify the Medicaid eligibility status of each recipient prior to rendering services.

5. Providers must inform the recipient of their financial responsibility before rendering any uncovered service.

6. For details on reporting Incidents and Serious Occurrences refer to Section 2103.2A.7.

7. For information on notification of suspected abuse, neglect, exploitation, isolation, or abandonment refer to Section 2103.2A.8.

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

9. Each provider must cooperate with DHCFP and/or State or Federal reviews or inspections.

2103.14C RECIPIENT RIGHTS AND RESPONSIBILITIES

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

1. Notify the provider(s) and Care Coordinator of a change in Medicaid eligibility.

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

3. Notify the provider(s) and Care Coordinator of changes in medical status, service needs, address, and location, or changes of designated representative/LRI.

4. Notify the provider when scheduled visits cannot be kept.

5. Not request a provider to perform services not included in the PCP.

6. Contact the Care Coordinator to request a change of provider.

7. The recipient and/or designated representative/LRI must sign and date all required forms.

2103.~~14~~15 INTAKE PROCEDURES

A. WAIVER REFERRAL AND PLACEMENT ON THE WAIT LIST

1. A referral or inquiry for the waiver may be made by a potential applicant or by another party on behalf of the potential applicant by contacting the local ADSD Regional Center. The Regional Center staff will discuss waiver services, including eligibility requirements with the referring party or potential applicant.

2. The Service Coordinator must conduct a LOC screening to verify eligibility for the wait list.

NOTE: If the applicant does not meet an LOC, they will receive a Notice of Decision (NOD) which includes the right to a fair hearing.

3. All applicants who meet waiver criteria must be placed on the statewide waiver wait list by priority and referral date. The following must be completed before placement on the wait list:

A. The applicant must meet LOC criteria for placement in an ICF/IID.

B. The applicant must require at least one ongoing waiver service.

C. The applicant must meet criteria for an intellectual or developmental disability.

Applicants will be sent a NOD indicating "no slot available. ~~The~~ ADSD will notify the DHCFP Long Term and Services and Supports (LTSS) Unit when no slot is available. The applicant will remain on the waiting list until a waiver slot is available.

The allocation of waiver slots is maintained with ~~the~~ ADSD. As waiver slots become available, ADSD determines how many slots may be allocated.

B. WAIVER SLOT ALLOCATION

Once a waiver slot is allocated by ~~the~~ ADSD, the applicant will be processed for the waiver.

The procedure used for processing an applicant will be as follows:

1. The ADSD Service Coordinator will schedule a face-to-face visit with the applicant

to complete the full waiver assessment to include diagnostic data, LOC determination, and will obtain all applicable forms, including but not limited to the Authorization for Release of Information.

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

The ADSD Service Coordinator will inform the applicant and/or designated representative/LRI that, pursuant to NRS 232.357, the Divisions within the Nevada Department of Health and Human Services (DHHS) may share confidential information between themselves without a signed authorization for release of information.

The Service Coordinator will provide an application to apply for Medicaid benefits through DWSS if the applicant does not have these benefits already in place. The applicant is responsible for completing the application and submitting all requested information to DWSS. The Service Coordinator will assist upon request.

2. The applicant/recipient will be given the right to choose waiver services in lieu of placement in an ICF/IID. If the applicant/recipient and/or designated representative/LRI prefers placement in an ICF/IID, the service coordinator will assist the applicant/recipient in arranging for facility placement.

3. The applicant/recipient will be given the right to request a hearing if not given a choice between HCBS Waiver and ICF/IID placement.

4. When the applicant/recipient is approved by ~~the~~ ADSD for the ID Waiver services, the following will occur:

   a. A team meeting is held, and a written PCP is developed in conjunction with the recipient and the PCP Team to determine specific service needs and to ensure the health and welfare of the recipient. The applicant/recipient and/or designated representative/LRI and provider(s) must sign and date the PCP. Interim PCP's, unsigned by the applicant/recipient and/or designated representative/LRI and the provider(s), may be authorized for up to 60 days from the PCP development meeting.

   NOTE: Applicant/recipients already receiving services via ~~the~~ ADSD State General Funds will already have a PCP in place.

b. The applicant/recipient, the applicant/recipient's family, or the designated representative/LRI, providers, and participants of the applicant/recipient's choice are included in the development of the PCP.

c. Applicants/recipients will be given the free choice of all qualified available Medicaid providers of each Medicaid covered service included in the written individual support plan. Current PCP must be given to all service providers and kept in the recipient's record.

d. All forms must be complete with signatures and/or initials and dates by the applicant/recipient and/or designated representative/LRI and provider(s), where required. Electronic signatures are acceptable, as pursuant to NRS 719, on forms that require a signature.

e. ~~The~~ ADSD will forward a completed waiver packet requesting to add a benefit plan to the DHCFP LTSS Unit.

1. The HCBS Waiver Eligibility Status form will be sent by the DHCFP ~~Central Office Waiver~~ LTSS Unit to the ADSD Service Coordinator.

2. ~~The~~ ADSD is responsible for notifying the DWSS of approval to coordinate waiver slot allocation.

3. ~~The~~ DWSS is responsible for notifying the ADSD of the applicants' status, to initiate waiver services.

C. SUPPORT PLAN DEVELOPMENT

Developmental Services uses a person-directed planning process. Assessment information assists the team with identifying barriers to reaching the person's vision, desired outcomes, and support needs. Goals related to reaching the vision are developed based on the person's desired life outcomes, as well as any needs for maintaining appropriate health and welfare. This information is provided to the person-centered team for plan development at the PCP meeting. This process provides direction for the identification of goals and assures that the meeting focuses on the participant and his or her priorities, preferences, and perspective.

The PCP is developed utilizing applicable assessments that may include a social assessment, health assessment, risk assessment, or self-medication administration assessment tool.

The support plan is inclusive of the services and supports that are provided to meet the

assessed needs of the participant. The service coordinator is responsible for understanding all services provided to the service recipient, gathering assessment, information, developing the PCP based on team recommendations, facilitating plans for any necessary referrals, and monitoring all services, as part of the support plan implementation. The support plan also identifies the priority areas to be addressed based upon the person-centered planning process. The PCP will identify which priority areas of support require habilitation plans. Additional supports, including general supervision, can be provided as needed to assist the individual with their daily life living in the community without the need for habilitation plans.

In addition to 42 CFR 443.301(c)(2)(i)-(xii), any modifications of the Support Plan must be supported by a specific assessed need and justified in the PCP. The following requirements must be documented in the PCP:

1. Identify a specific and individualized assessed need.

2. Document the positive interventions and supports used prior to any modifications to the person-centered service plan.

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

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

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

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

7. Include the informed consent of the individual.

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

D. EFFECTIVE DATE FOR WAIVER SERVICES

The effective date for waiver services approval is the completion date of all the intake forms, or the waiver eligibility determination date by ~~the~~ DWSS, whichever is later. If the applicant is in an institution, the effective date cannot be prior to the date of discharge from the institution.

Waiver services will not be backdated beyond the first of the month in which the waiver eligibility determination is made by the DWSS.

E. SERVICE COORDINATION

Service Coordination is provided under the Medicaid State Plan Targeted Case Management service. This is an integral part of the management of the ID Waiver.

Refer to MSM Chapter 2500 for allowable activities under Targeted Case Management.

F. 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 Medicaid State Plan that would have been made in that fiscal year, had the waiver not been granted.

2103.1~~5~~6 PERMANENT CASE FILE

A. For each approved ID Waiver recipient, the Service Coordinator must maintain a permanent record that documents services provided under the ID Waiver. The service provider is also required to maintain their billing documents and service records.

B. These records must be retained for six years from the date the last claim is paid.

2103.1~~6~~7 SERVICE COORDINATOR RECIPIENT CONTACTS

A. Recipient Contact

1. The Service Coordinator must have monthly contact with each waiver recipient, or a recipient's designated representative/LRI, or the recipient's Supported Living or Jobs and Day Training provider. The contact must be sufficient to address health and safety needs of the recipient, needed support plan changes, recipients' goals and satisfaction with services and supports. At a minimum, there must be a face-to-face visit with each recipient quarterly.

2. During quarterly contacts, the Service Coordinator will monitor whether the habilitation plans are meeting identified goals and provide any necessary follow up on needs or concerns.

   a. The Service Coordinator must show due diligence to hold the established contacts as outlined in the PCP and every attempt to contact the recipient

must be documented. At least three attempts must be completed on separate days within the quarter, if no response is received after the 3rd attempt, a letter must be sent to the recipient requesting a return contact. If the recipient fails to respond by the date indicated in the letter, the recipient may be terminated.

b. When DHCFP is conducting a review of a recipient and the Service Coordinator has clearly documented the above steps were attempted during any given quarter wherein a quarterly contact was required, DHCFP shall waive that quarterly contact requirement.

B. Reassessment

1. Recipients must be reassessed at least annually within the same month. The recipient and provider(s) must sign and date the PCP. Interim PCP's, unsigned by the recipient and provider(s), may be authorized for up to 60 days.

2. The recipient must also be reassessed when there is a significant change in his/her condition.

3. The number of hours specified on each recipient's Service Authorization for each specific service, are considered the maximum number of hours allowed to be provided by the provider and paid by ~~the~~ ADSD and ~~the~~ DHCFP, unless the Service Coordinator has approved additional hours due to a temporary condition or circumstances. Providers are allowed to provide fewer services than stated on the Service Authorization if the reason for providing less service is adequately documented.

4. When the recipient's service needs increase, due to a temporary condition or circumstance, the Service Coordinator must thoroughly document the increased service needs in their case notes. The PCP does not need to be revised for temporary conditions or circumstances. A temporary condition or circumstance is defined as an increase or decrease in service needs for a period not to exceed 30 days.

5. Residential Support Management hours are defined in the PCP. A temporary increase in the residential support management hours for the recipient must receive prior authorization from the ADSD, within the month of the temporary increase, and be justified based on health, safety and welfare concerns. If an increase is warranted to exceed a 30-day period, there must be a reassessment based on thorough documentation in the Residential Support Managers case notes reflecting the health, safety and welfare concerns and the Service Authorization must be revised.

d. The State assures overall health and safety and monitors these assurances based on the responsibility of the service provider as stated in the approved waiver.

5. Financial Accountability: The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver.

a. The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

b. The State provides evidence that rates remain consistent with the approved rate methodology through the five-year waiver cycle.

6. Administrative Authority: DHCFP retains ultimate administrative authority and responsibility for the operation of the waiver by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

The annual review is conducted using the above assurances and sub assurances as well as state specified performance measures identified in the approved ID waiver in order to evaluate the operation of the waiver.

Providers must cooperate with DHCFP's annual review process.

2103.~~19~~20 MEDICAID PROVIDER ENROLLMENT PROCESS

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

2. All providers must comply with all DHCFP ADSD enrollment requirements, provider responsibilities/qualifications, DHCFP ADSD provider agreement and limitations set forth in this chapter.

3. Provider non-compliance with all or any of these stipulations may result in ~~the~~ DHCFP's decision to exercise its right to terminate the provider's contract.

2104 HEARINGS REQUEST DUE TO ADVERSE ACTIONS

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

2104.1 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 an institutional setting, such as a hospital, a NF, or ICF/IID).

B. After receiving written notification from the Service Coordinator with the admission date and the request for suspension of waiver services, a NOD identifying the effective date and the reason for suspension will be provided to the recipient by the DHCFP LTSS unit.

C. If at the end of 60 days the recipient has not been removed from suspension status, the waiver must be terminated.

D. The DHCFP LTSS unit sends a NOD to the recipient and/or designated representative/LRI advising them of the date and reason for the waiver closure/termination.

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

2104.2 RELEASE FROM SUSPENDED WAIVER SERVICES

When a recipient has been released from the hospital, NF or an ICF/IID before 60 days from the admit date, the Service Coordinator must do the following within five working days:

A. Notify the DHCFP LTSS Unit of the release of suspension.

B. Complete a new PCP if there has been a significant change in the recipient's condition needs. If a change in services is expected to resolve in less than 30 days, a new PCP is not necessary. Documentation of the temporary change must be made in the Service Coordinator's notes. The date of the resolution must also be documented in the Service Coordinator's notes.

C. Complete a new Service Authorization, if necessary.

D. Contact the service providers(s) to re-establish services.

2104.3 DENIAL OF WAIVER APPLICATION

Reasons an applicant will be denied for waiver services:

a. The applicant does not meet the criteria of being diagnosed with intellectual or developmental disability.

b. The applicant does not meet the LOC criteria for placement in an ICF/IID).

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

d. The applicant fails to cooperate with the Service Coordinator or the HCBS providers in establishing and/or implementing the PCP implementing waiver services or verifying eligibility for waiver services.

e. The applicant's support system is not adequate to provide a safe environment during the time when HCBS are not being provided. HCBS services are not a substitute for natural and informal supports provided by family, friends or other available community resources.

f. The applicant fails to show a need for HCBS.

g. The applicant would not require imminent placement in an ICF/IID if HCBS were not available. (Imminent placement means within 30 to 60 days.)

h. Another agency or program will provide the services.

i. ~~The~~ ADSD has filled the number of slots allocated to the ID Waiver. The applicant has been approved for the waiver waitlist and will be contacted when a slot is available.

j. The applicant has moved out of state.

k. The agency has lost contact with the applicant.

When the application for waiver services is denied, the DHCFP LTSS Unit will issue a Notice of Decision (NOD), within five business days, to the recipient or designated representative/LRI identifying the reason for denial. The Date of Action (DOA) is the same date as the NOD date.

2104.4 TERMINATION OF WAIVER SERVICES

Reasons to terminate a recipient from the waiver:

A. The recipient no longer meets the criteria of an intellectual or developmental disability.