

Joe Lombardo
Governor

Richard Whitley, MS
Director



DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF HEALTH CARE FINANCING AND POLICY

Helping people. It's who we are and what we do.



Stacie Weeks,
JD MPH
Administrator

- Description of how the state's oversight systems (licensure and certification standards, provider manuals, person-centered plan monitoring by case managers, etc.) have been modified to embed the regulatory criteria into ongoing operations.

State Response:

Once the Transition process is complete, the State will work with Medicaid new and existing Home and Community Based Services (HCBS) providers during enrollment and recertification/revalidation process to ensure complete compliance with the Settings Requirements.

Entities that wish to enroll and at revalidation (re-enrollment) as HCBS Providers will be subject to site visit verification that they meet settings requirements as part of the enrollment process. New site visit assessment form will be created to use on new Medicaid providers. Additionally, enrollment checklist form has been updated and included a link to the HCBS Final Regulation information that must be read, understand, and signed (attestation).

24-Hour SLA and Shared Living SLA: DHCFP will meet with ADSD to ensure that their certification process meets this requirement which states: individuals to have privacy in their sleeping or living unit: Individuals sharing units have a choice of roommates in that

Any modifications/exceptions must be supported by a specific assessed need and justified in the person-centered service plan.

The state has in-place ongoing monitoring through site visits as part of provider reviews of both residential and non-residential facilities. The HCBS Final Regulation requirements will be incorporated into the existing comprehensive review tool that is currently used by quality assurance to review providers on an ongoing basis.

The state will include training of case managers to ensure the provider settings are compliant with the regulation during site visits. ADSD and DHCFP Quality Assurance units will include this regulation as part of their review. The Medicaid Service Manual (MSM) will also be updated to reflect the new requirements.

- Description of how the state assesses providers for initial compliance and conducts ongoing monitoring for continued compliance.

State Response:

Entities that wish to enroll as HCBS Providers will be subject to site visit verification that they meet settings requirements as part of the enrollment process.

New site visit assessment form will be created to use on new Medicaid providers.

Once the Transition process is complete, the State will work with our providers during recertification/revalidation to ensure complete compliance with the New Rule Regulations are met.

The monitoring of compliance with the HCBS Final Regulation will be incorporated into the ongoing provider reviews performed by DHCFP and ADSD QA units, which on an annual basis, conducting 100% review of all HCBS waiver providers. For 1915i providers, provider reviews will be conducted at initial and at revalidation. Additionally, to assure providers remain compliant with the settings requirements is through case managers contact with the recipients. Contact form will be updated to reflect relevant questions referencing settings requirements such as “do you have access to food at any time”, are you able to participate in outside activities (what are those)”, “are you allowed to have visitors at any time”. For new Medicaid provider enrollees, prior to enrollment, DHCFP will be conducting on-site visits to ensure new providers comply with the setting’s rule prior to rendering services to HCBS recipients.

Providers have been informed during the initial on-site assessment and at the final validation of the ongoing monitoring to ensure continued compliance with the HCBS Final Regulation. Additionally, at time of provider enrollment, providers will be informed of the ongoing monitoring of settings requirements compliance through provider reviews. As part of the HCBS Waivers and 1915i Health and Welfare assurance requirements, that providers must meet the standards of any state licensure or certification, provider reviews are conducted during initial, annually and at revalidation. If deficiencies are found, the providers are given the opportunity to rebuttal and respond within 30 days of the notification. The settings requirements will be added to the existing provider review and there will be no change in the process in terms of the HCBS assurance that providers must comply with provider requirements and Nevada Medicaid Services Manual (MSM) Chapter 102.2 <https://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/C100/Chapter100/>.

If providers do not come into compliance within required time frames, they will be terminated as Medicaid providers.

Providers will be given the opportunity to propose changes to come into compliance. However, if they do not accept this opportunity, or are unable to make the required changes, they will be terminated.

The State will create a letter detailing the process, so the providers know why they are being terminated.

Providers that do not meet setting requirements will not be initially enrolled or re-enrolled.

- Description of a beneficiary’s recourse to notify the state of provider non-compliance (grievance process, notification of case manager, etc.) and how the state will address beneficiary feedback.

State Response:

Within the Settings requirements there is a requirement that each facility has information on how a beneficiary can contact the state ombudsman, adult protective services, and their own case manager. Most of the time this information would be posted in a conspicuous location within the residence. Further, as part of the health and welfare assurance, case managers regularly make contact (frequency is determined through the person-centered development stage) with recipients to ensure their health, safety and welfare are being addressed and if satisfied with or needing additional services, now will also include the settings requirements.

Beneficiaries are also provided a “Recipient Rights” form to provide information to beneficiaries on their rights while receiving Home and Community Based Services, and how to file grievances, complaints or to report abuse, neglect, or exploitation. The “Recipient Rights” form also provides the beneficiary with their case manager’s information in the event they wish to discuss any issues or needs with the case manager. The “Recipient Rights” form is reviewed with the recipient during their initial assessment and at least annually thereafter.

Beneficiaries are also provided a “Statement of Choice” form where they are provided a choice between community living or remain in the nursing facility, choice of providers, information about fair hearings rights.