Home and Community Based Services Waiver for the Frail Elderly

Specialty 303: Private Case Management Services

Case management is provided to eligible recipients enrolled in Home and Community Based Services (HCBS) Waiver programs and must be identified as a service on the Plan of Care (POC). Case Management providers are responsible for confirming the recipient's eligibility each month prior to rendering waiver services. The recipient has a choice of case management providers who are actively enrolled with the Division of Health Care Financing and Policy (DHCFP) under provider type (PT) 48.

The following is a list of enrollment documents and requirements for this provider type. A copy of each document listed below must be included with your provider enrollment or revalidation. Revalidation is required every five (5) years.

If you have any questions, please contact Provider Customer Service at (877) 638-3472 from 8:00 a.m. to 5:00 p.m. Monday through Friday.

Entity/Group

- ☐ Meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to the DHCFP Medicaid Services Manual (MSM), Chapter 100 and Chapter 2200, as applicable.
- ☐ Documentation showing Taxpayer Identification Number (SS-4 or CP575 or W-9)
- ☐ Nevada Secretary of State Business License
- ☐ Proof of Worker's Compensation Insurance
- ☐ Proof of Unemployment Insurance
- ☐ Proof of Commercial General Liability Insurance of not less than $2 million general aggregate and $1 million each occurrence, with the Nevada Division of Health Care Financing and Policy (DHCFP) named as an additional insured. DHCFP's address is 1100 E. William St., Ste. 101, Carson City, Nevada 89701.
- ☐ Proof of Commercial Crime Insurance for employee dishonesty with a minimum of $25,000 per loss. The policy must name DHCFP as an additional insured.
- ☐ Do you provide transportation in any owned, leased, hired and non-owned vehicles?

  ☐ Yes ☐ No

  If you answered "yes" you must provide proof of Business Automobile Insurance, with a minimum coverage of $750,000 combined single limit for bodily injury and property damage for any owned, leased, hired and non-owned vehicles used in the performance of the Medicaid provider's contract. The policy must name DHCFP as an additional insured and shall be endorsed to include the following language: "The State of Nevada shall be named as an additional insured with respect to liability arising out of the activities performed by, or on behalf of the Contractor, including automobiles owned, leased, hired or borrowed by the Contractor."
- ☐ Signed Business Associate Addendum (NMH-3820). The Addendum is available at https://www.medicaid.nv.gov on the "Provider Enrollment" webpage under "Required Enrollment Documents."

All providers must complete the following declaration and attestations and provide this signed checklist with the provider enrollment/revalidation.

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Policy Declaration

I hereby declare that as of this date, I have read the current Medicaid Services Manual (MSM) Chapters 100 and 2200, which can be found at http://dhcfp.nv.gov and selecting "Medicaid Manuals" from the Index box. I attest that I understand these Policies and how they relate to my scope of practice. I acknowledge that, as a Nevada Medicaid contracted provider, I am responsible for complying with the MSM, with any updates to Policy as may occur from time to time, and with all applicable state and federal laws.

I attest I have read, understand, and will comply with the following requirements detailed within MSM Chapter 2200:

- I am responsible for ensuring that all owners, administrators, managing employees, and all other employees providing case management services have a fingerprint-based criminal background check through the Department of Public Safety and Federal Bureau of Investigation. Failure to comply may result in administrative action, including recoupment of Medicaid reimbursement and/or termination from the Medicaid program.
- I have a business office that is accessible to the public during established and posted business hours.
- I have a fixed business landline telephone number published in a public telephone directory.

Once fully enrolled as a Medicaid provider, I understand and agree that the state may conduct provider reviews to validate that the above requirements detailed in Chapter 2200 are met.

Owner/Authorized Representative Signature: _____Date: _____

Information Changes

If your information changes from what is presented above and on your enrollment application, you are required to notify Nevada Medicaid within the time frame required in Chapter 100 Section 103 Reporting Requirements. Changes in business ownership must be reported by submitting a new enrollment application and indicating ownership change. All ownership changes must include documentation of the purchase agreement. All other changes must be reported by using the Provider Web Portal at https://www.medicaid.nv.gov/hcp/provider/Home/tabid/135/Default.aspx. After logging in, click on the "Revalidate – Update Provider" link under Provider Services. The Online Provider Enrollment User Manual Chapter 3 Revalidation and Updates on the Provider Enrollment webpage at https://www.medicaid.nv.gov provides instructions on navigating the Update Provider tool.

Per MSM Chapter 100, Section 103.3: "Medicaid providers, and any pending contract approval, are required to report, in writing within the time frame required in Chapter 100 Section 103 Reporting Requirements, any change in ownership, address, or addition or removal of practitioners, or any other information pertinent to the receipt of Medicaid funds. Failure to do so may result in termination of the contract at the time of discovery."

I hereby accept Nevada Medicaid's change notification requirements:

Owner/Authorized Representative Signature: _____Date: _____

HCBS Final Regulation Declaration

The Centers for Medicare and Medicaid Services (CMS) has issued a regulation regarding several sections of the Medicaid law under which states offer Home and Community Based Services (HCBS). The regulation

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reflects CMS' intent to ensure that individuals receiving services and supports through Medicaid's HCBS programs have full access to the benefits of community living and can receive services in the most integrated setting possible.

I hereby declare that as of this date, I have read the HCBS Final Regulations Settings Requirements which can be found at https//www.dhcfp.nv.gov/Home/HCBS/FinalRegulation/ and by selecting "*Summary of HCBS Settings Requirement*" from the links on the page. I attest that I understand the settings requirements and how they relate to my scope of practice. I acknowledge that, as a Medicaid waiver provider, I am responsible for complying with the HCBS Final Regulation and with any updates to the Settings Requirements as they may occur from time to time.

Owner/Authorized Representative Signature: _____Date: _____

Reporting Fraud

Providers have an obligation to report to the Division of Health Care Financing and Policy (DHCFP) any suspicion of fraud or abuse in DHCFP programs, including fraud or abuse associated with recipients or other providers (MSM Chapter 3300, Section 3303.1B.1). Examples of fraudulent acts, false claims and abusive billing practices are listed in MSM Chapter 3300, Section 3303.1A.2. Alleged fraud, abuse or improper payment may be reported by calling (775) 687-8405 or completing the form on the DHCFP website at https://dhcfp.nv.gov/Resources/PI/ContactSURSUnit/.

I understand that Nevada Medicaid payments are made from federal and state funds and that any falsification or concealment of a material fact, may be prosecuted under federal and state laws.

I hereby agree to abide by Nevada Medicaid's fraud reporting requirements.

Owner/Authorized Representative Signature: _____Date: _____

Owner/Authorized Representative Attestation

I certify under penalty of perjury under the laws of the State of Nevada, that the information I have provided is true and correct and that I have read, understood, and agree to comply with all parts of this Provider Enrollment Checklist.

Owner/Authorized Representative Signature: _____Date: _____