# Table of Contents

**State/Territory Name: Nevada**

**State Plan Amendment (SPA) #: 16-005**

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706


**DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS**

March 10, 2016

Richard Whitley, Director
Department of Health and Human Services
4126 Technology Way, Suite 100
Carson City, NV 89706

Dear Mr. Whitley:

Enclosed is an approved copy of Nevada State Plan Amendment (SPA) 16-005. The SPA proposes to change the reference of "Intermediate Care Facility for the Mentally Retarded (ICF/MR) to "Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) and to change the eligibility worker from Case Manager at the Division of Welfare and Supportive Services (DWSS) to Case Manager at the Department of Health Care Financing and Policy (DHCFP). It was submitted to my office on January 27, 2016.

The approval is effective January 28, 2016. Attached is a copy of the following page to be incorporated into your State Plan:

- Supplement 3 to Attachment 2.2-A, Page 1

If you have any questions, please contact Peter Banks by phone at (415) 744-3782 or by email at Peter.Banks@cms.hhs.gov.

Sincerely,

/s/

Kristin Dillon
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure

cc: Marta Jensen, Administrator, DHCFP

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

**TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 16-005 PD ~~15-011~~

2. STATE: NEVADA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: January 28, 2016 PD ~~December 11, 2015~~

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 435.225

7. FEDERAL BUDGET IMPACT:
a. FFY ~~2014~~2016 PD $0
b. FFY ~~2015~~2017 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Supplement 3 to Attachment 2.2-A, Page 1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Supplement 3 to Attachment 2.2-A, Page 1

10. SUBJECT OF AMENDMENT: The specific changes being made are as follows: Change Intermediate Care Facility for the Mentally Retarded (ICF/MR) to Intermediate care Facility for Individuals with Intellectual Disabilities (ICF/IID) and the eligibility worker to Case Manager at the Division of Health Care Financing and Policy (DHCFP) instead of the Division of Welfare and Supportive Services (DWSS), for the notification of exceeding allowable costs. DWSS is not involved in the programmatic operations of this eligibility option. There is no change in eligibility, Maintenance of Effort (MOE), or anticipated financial impact for these changes.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
Richard Whitley

14. TITLE:
Director, Department of Health and Human Services

15. DATE SUBMITTED:
January 27, 2016

16. RETURN TO:
Tammy Moffitt, Chief of Program Integrity
DHCFP/Medicaid
1100 East William Street, Suite 101
Carson City, NV 89701

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED: 1/27/16

18. DATE APPROVED: 3/10/16

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 1/28/16

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Kristin Dillon

22. TITLE: Acting Associate Regional Administrator

23. REMARKS:
Three pen and ink changes were requested by NV: 1. Change SPA number from 15-011 to 16-005 (Box 1). 2. Update the effective date from 12/11/15 to 1/28/16 (Box 4). 3. Update FFY 2014 and FFY 2015 to FFY 2016 and FFY 2017 (Box 7).

STATE/TERRITORY: NEVADA

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

METHOD FOR DETERMINING COST EFFECTIVENESS OF CARING FOR CERTAIN DISABLED CHILDREN AT HOME (KATIE BECKETT)

At the end of each calendar quarter, a computerized list of approved Katie Beckett Eligibility Option cases is generated by the Division of Health Care Financing and Policy (DHCFP) staff. The list shows the total Medicaid expenditure amount incurred quarterly which is compared to the maximum allowable costs. The maximum allowable costs are the costs of institutionalization in either a Skilled Nursing Facility (SNF), or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID), which is determined by a level of care assessment. If the amount exceeds the maximum allowable, the Case Manager at the appropriate DHCFP office notifies the participant and advises him/her: 1) of the requirement to keep costs at or below the maximum allowable amount; and 2) that failure to keep costs to allowable amounts will result in termination from the program. If the participant's incurred costs exceed the maximum allowable amount for two consecutive quarters, he/she will be terminated from the program effective the first day of the month following the date of the determination for non-compliance with program requirements.

A level of care assessment is conducted annually; therefore, allowable costs may fluctuate annually based on the individual recipient's Level of Care (LOC).