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State/Territory Name: Nevada

State Plan Amendment (SPA) #: 20-0003

This file contains the following documents in the order listed:

1) Approval Letter
2) 179 Form
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

Medicaid and CHIP Operations Group

August 11, 2020

Suzanne Bierman, Administrator
Department of Health and Human Services
Division of Health Care Financing and Policy
1100 East William Street, Suite 101
Carson City, NV 89701

RE: NV-20-0003 new §1915(i) Home and Community-based Services state plan benefit

Dear Ms. Bierman:

The Centers for Medicare and Medicaid Services (CMS) is approving the state's request to amend your state plan to add a new §1915(i) Home and Community-based Services (HCBS) benefit, transmittal number NV-20-0003. This action is approved on August 7, 2020. The effective date for the §1915(i) benefit is July 1, 2020. Enclosed is a copy of the approved state plan amendment (SPA).

Since the state has elected to target the population who can receive this §1915(i) State Plan HCBS benefit, CMS approves this SPA for a five-year period expiring June 30, 2025, in accordance with §1915(i)(7) of the Social Security Act. To renew the §1915(i) State Plan HCBS benefit for an additional five-year period, the state must submit a renewal application to CMS by January 1, 2025, at least 180 days prior to the end of the approval period. CMS' approval of a renewal request is contingent upon state adherence to federal requirements and the state meeting its objectives with respect to quality improvement and beneficiary outcomes.

Per 42 CFR §441.745(a)(i), the state will annually provide CMS with the projected number of individuals to be enrolled in the benefit and the actual number of unduplicated individuals enrolled in the §1915(i) State Plan HCBS program in the previous year. Additionally, at least 21 months prior to the end of the five-year approval period, the state must submit evidence of the state's quality monitoring in accordance with the Quality Improvement Strategy in their approved state plan amendment. The evidence must include data analysis, findings, remediation, and describe any system improvement for each of the §1915(i) requirements.

It is important to note that CMS' approval of this new §1915(i) HCBS state plan benefit solely addresses the state's compliance with the applicable Medicaid authorities. CMS' approval does not address the state's independent and separate obligations under federal laws including, but not limited to, the Americans with Disabilities Act, §504 of the Rehabilitation Act, or the Supreme Court's Olmstead decision. Guidance from the Department of Justice concerning compliance with the Americans with Disabilities Act and the Olmstead decision is available at http://www.ada.gov/olmstead/q&a_olmstead.htm.

If you have any questions concerning this information, please contact me at (206) 615-2356, or your staff may contact Elizabeth Heintzman at Elizabeth.heintzman@cms.hhs.gov or (206) 615-2596.

Sincerely,

David L. Meacham, Director
Division of HCBS Operations and Oversight

Enclosure

cc:
DuAne Young, Nevada Department of Health and Human Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER
2 0 — 0 0 3

2. STATE
NEVADA

3. PROGRAM IDENTIFICATION:
TITLE XIX OF THE SSA (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
~~April 1, 2020~~ July 1, 2020

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 441 Subpart M

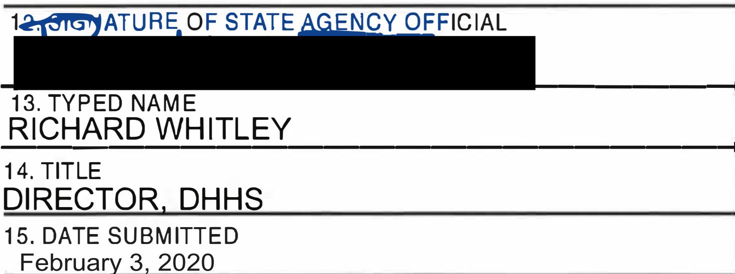
7. FEDERAL BUDGET IMPACT
a. FFY ~~2019~~ 2020 $ ~~1,160,959.08~~ $ 744,923
b. FFY ~~2020~~ 2021 $ ~~4,643,436~~ $2,979,693

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-i2 pages 1-45
Attachment 4.19-B pages 18-8f
Attachment 2.2-A pages 1-2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Not applicable as this is a new page

10. SUBJECT OF AMENDMENT
1915(i) State Plan Home and Community-Based Services Administration and Operation

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



12. SIGNATURE OF STATE AGENCY OFFICIAL

13. TYPED NAME
RICHARD WHITLEY

14. TITLE
DIRECTOR, DHHS

15. DATE SUBMITTED
February 3, 2020

16. RETURN TO
Cody L. Phinney, Deputy Administrator
DHCFP/Medicaid
1100 East William Street, Suite 101
Carson City, NV 89701

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED 2/3/2020

18. DATE APPROVED 8/7/2020

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL 7/1/2020

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME
David L. Meacham

22. TITLE
Director, Division of HCBS Operations and Oversight

23. REMARKS
4/16/2020-State authorizes P&I change to block #4
4/13/2020-State authorizes P&I changes to blocks # 4, 7, and 8

FORM CMS-179 (07/92) ***Instructions on Back***

1915(i) State plan Home and Community-Based Services Administration and Operation

The state implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit *for elderly and disabled individuals as set forth below.*

1. Services. *(Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):*

1. Intensive In-Home Services and Supports
2. Crisis Stabilization Services

2. Concurrent Operation with Other Programs. (*Indicate whether this benefit will operate concurrently with another Medicaid authority)*:

***Select one*:**

●	**Not applicable**
○	**Applicable**
	Check the applicable authority or authorities:
☐	**Services furnished under the provisions of §1915(a) (1) (a) of the Act.** The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. *Specify:* *(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);* *(b) the geographic areas served by these plans;* *(c) the specific 1915(i) State plan HCBS furnished by these plans;* *(d) how payments are made to the health plans; and* *(e) whether the 1915(a) contract has been submitted or previously approved.*
☐	**Waiver(s) authorized under §1915(b) of the Act.** *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*
	Specify the §1915(b) authorities under which this program operates (*check each that applies*):

☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)

☐	§1915(b)(2) (central broker)	☐ §1915(b)(4) (selective contracting/limit number of providers)

☐ **A program operated under §1932(a) of the Act.**
Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1115 of the Act.** *Specify the program*:

3. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit. *(Select one)*:

○	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:	
	○	The Medical Assistance Unit *(name of unit)*:
	○	Another division/unit within the SMA that is separate from the Medical Assistance Unit *(name of division/unit) This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.*
●	The State plan HCBS benefit is operated by *(name of agency)* Division of Child and Family Services	
	a separate agency of the state that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.	

4. Distribution of State plan HCBS Operational and Administrative Functions.

☑ *(By checking this box the state assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	☑	☑	☑	☑
2 Eligibility evaluation	☑	☑	☑	☑
3 Review of participant service plans	☑	☑	☑	☑
4 Prior authorization of State plan HCBS	☑	☐	☑	☐
5 Utilization management	☑	☐	☑	☐
6 Qualified provider enrollment	☑	☑	☑	☑
7 Execution of Medicaid provider agreement	☑	☑	☐	☑
8 Establishment of a consistent rate methodology for each State plan HCBS	☑		☐	☐
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☑	☐	☑
10 Quality assurance and quality improvement activities	☑	☑	☑	☑

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

Medicaid Agency - Division of Health Care Financing and Policy (DHCFP)
Other State Operating Agency- Division of Child and Family Services (DCFS)
Contracted Entity- Fiscal Agent Contractor (FAC), Wraparound Process Contractor (WPC)
Local Non-State Entity - Clark County Department of Family Services (CCDFS), Washoe County Human Services Agency (WCHSA)

Function #1. DHCFP will provide oversight of DCFS and their contracted entities (WPC) as applicable who perform the individual State plan HCBS enrollment.
Function #2. DHCFP performs eligibility evaluation oversight of DCFS and their contracted entities as applicable (WPC).
Function #3. DHCFP provides oversight of the following partners who review of participant service plans: DCFS and contracted entities (WPC).
Function #4. DHCFP or their FAC is responsible for Prior Authorization (PA) activities.
Function #5. Utilization Management may be performed by DHCFP or their FAC.
Function #6. Qualified provider enrollment is performed by DHCFP, FAC, DCFS, CCDFS, and WCHSA.
Function #7. DHCFP and DCFS have responsibility for the execution of Medicaid provider agreement(s).
Function #8. Establishment of a consistent rate methodology for each State plan HCBS is the responsibility of DHCFP and DCFS.
Function #9. DHCFP and DCFS are responsible for rules, policies, procedures, and information development governing the State plan HCBS benefit.
Function #10. Quality assurance and quality improvement activities are performed by DHCFP, DCFS, CCDFS, WCHSA, and WPCs.

(By checking the following boxes the State assures that):

5. ☑ **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual, or any paid caregiver of the individual
- financially responsible for the individual
- empowered to make financial or health-related decisions on behalf of the individual
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*

6. ☑ **Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. ☑ **No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. ☑ **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. **Projected Number of Unduplicated Individuals To Be Served Annually.**
(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	7/1/2020	12/31/2020	475
Year 2			
Year 3			
Year 4			
Year 5			

2. ☑ **Annual Reporting.** *(By checking this box the state agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

Financial Eligibility

1. ☑ **Medicaid Eligible.** *(By checking this box the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a) (10) (A) (ii) (XXII) of the Social Security Act. States that want to adopt the §1902(a) (10) (A) (ii) (XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

2. **Medically Needy** (*Select one*):

☑ The State does not provide State plan HCBS to the medically needy.
☐ The State provides State plan HCBS to the medically needy. (*Select one*):
☐ The state elects to disregard the requirements section of 1902(a) (10) (C) (i) (III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services. ☐ The state does not elect to disregard the requirements at section 1902(a) (10) (C) (i) (III) of the Social Security Act.

Evaluation/Reevaluation of Eligibility

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*Select one*):

○	Directly by the Medicaid agency

●	By Other (*specify State agency or entity under contract with the State Medicaid agency*):
	DCFS, Clark County Department of Family Services (CCDFS), Washoe County Human Services Agency

2. **Qualifications of Individuals Performing Evaluation/Reevaluation**. The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

The Care Manager or Wraparound Facilitator who is responsible for performing evaluation/reevaluation of eligibility must be independent and have one of the following qualifications:

Qualified Mental Health Associate (QMHA) –

A person who meets the following documented minimum qualifications:

1. Licensure as a Registered Nurse (RN) in the State of Nevada or holds a bachelor's degree from an accredited college or university in a human, social services or behavioral field with additional understanding of RMH treatment services and case file documentation requirements; or
2. Holds an associate degree from an accredited college or university in a human, social services or behavioral field with additional understanding of RMH treatment services, and case file documentation and has four years of relevant professional experience of providing direct services to individuals with mental health disorders;
   or
3. An equivalent combination of education and experience as listed in 1-2 above; and
4. Whose education and experience demonstrate the competency under clinical supervision to:
   a. Direct and provide professional therapeutic interventions within the scope of their practice and limits of their expertise;
   b. Identify presenting problem(s);
   c. Participate in treatment plan development and implementation;
   d. Coordinate treatment;
   e. Provide parenting skills training;
   f. Facilitate discharge plans; and
   g. Effectively provide verbal and written communication on behalf of the recipient to all involved parties.
5. Has a Federal Bureau of Investigation (FBI) background check in accordance with the Qualified Behavioral Aides (QBA) provider qualifications listed under Section 403.6A of the Nevada MSM.

Qualified Mental Health Professional (QMHP) - A Physician, Physician's Assistant or a person who meets the definition of a QMHA and also meets the following documented minimum qualifications:

1. Holds any of the following educational degrees and licensure:
   a. Doctorate degree in psychology and license;
   b. Bachelor's degree in nursing and Advanced Practitioners of Nursing (APN) (psychiatry);
   c. Independent Nurse Practitioner; Graduate degree in social work and clinical license;
   d. Graduate degree in counseling and licensed as a marriage and family therapist or clinical professional counselor; or
2. Who is employed and determined by a state mental health agency to meet established class specification qualifications of a Mental Health Counselor; and
3. Whose education and experience demonstrate the competency to: identify precipitating events, conduct a comprehensive mental health assessment, diagnose a mental or emotional disorder and document a current ICD diagnosis, determine intensity of service's needs, establish measurable

goals, objectives and discharge criteria, write and supervise a treatment plan and provide direct therapeutic treatment within the scope and limits of their expertise.

The following are also considered QMHPs:

a. Licensed Clinical Social Worker (LCSW) Interns meet the requirements under a program of internship and are licensed as an intern pursuant to the State of Nevada, Board of Examiners for Social Workers (Nevada Administrative Code (NAC) 641B).
b. Licensed Marriage and Family Therapist (LMFT) and Licensed Clinical Professional Counselor Interns who meet the requirements under a program of internship and are licensed as an intern pursuant to the State of Nevada Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors.
c. Psychological Assistants who hold a doctorate degree in psychology, is registered with the State of Nevada Board of Psychological Examiners (NAC 641.151) and is an applicant for licensure as a Licensed Clinical Psychologist who has not yet completed the required supervised postdoctoral experience approved by the Board.
d. Psychological Interns registered through the Psychological Board of Examiners defined in NAC 641.165. Interns must be supervised in accordance with state regulations and may only provide services within the scope of their licensure.

3. **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

DCFS offers tiered care coordination services to best meet the needs of youth with serious emotional disturbance (SED). Youth with the highest level of need receive High Fidelity Wraparound and their Wraparound Facilitator will direct the process of eligibility for State plan HCBS and development of the Plan of Care (POC). Youth with intermediate level of need are offered FOCUS Care Coordination, an evidence-informed intermediate level care coordination program created by the National Wraparound Implementation Center which also provides training and technical assistance to Nevada in our implementation of High-Fidelity Wraparound. FOCUS Care Coordination is a new, evidence-informed intermediate level care coordination program created by the National Wraparound Implementation Center which also provides training and technical assistance to Nevada in our implementation of High-Fidelity Wraparound. FOCUS care coordination is built around the following elements of service: Families are laughing, i.e. positive relationships are necessary for healing; Outcomes; Coordination; Unconditional positive regard; and Short-term process (FOCUS). Youth receiving FOCUS will have a Care Manager directing the process of eligibility for State Plan HCBS and development of the POC.
While we anticipate that nearly all youth who are eligible for 1915(i) State plan benefit will also qualify for High Fidelity Wraparound due to intensive behavioral healthcare needs, we have included in this application the possibility that youth may be routed to FOCUS and may have a Care Manager leading their Child and Family Team.

The Care Manager/Wraparound Facilitator (CM/WF) and the Child and Family Team (CFT) will evaluate whether an individual meets the needs-based State plan HCBS eligibility criteria and whether the individual is eligible for the 1915(i)-state plan benefit. The CM/WF and the CFT will perform the evaluation based upon Nevada's definition of medically necessary treatment which states: Medical Necessity is a health care service or product that is provided for under the Medicaid State Plan and is necessary and consistent with generally accepted professional standards to:
A. diagnose, treat or prevent illness or disease;

B. regain functional capacity; or
C. reduce or ameliorate effects of an illness, injury or disability.

The determination of medical necessity is made on the basis of the individual case and takes into account:
D. the type, frequency, extent, and duration of treatment with scientifically based guidelines of national medical or health care coverage organizations or governmental agencies.
E. the level of service that can be safely and effectively furnished, and for which no equally effective and more conservative or less costly treatment is available.
F. that services are delivered in the setting that is clinically appropriate to the specific physical and mental/behavioral health care needs of the recipient.
G. that services are provided for medical or mental/behavioral reasons, rather than for the convenience of the recipient, the recipient's caregiver or the health care provider.

Medical necessity shall take into account the ability of the service to allow recipients to remain in a community-based setting, when such a setting is safe, and there is no less costly, more conservative, or more effective setting.

The CM/WF will be familiar with the medical necessity criteria and will use criteria and the individual's clinical history to facilitate the determination of eligibility.

Re-evaluation occurs every 90 days and includes a re-determination of medical necessity on the basis of the individual case and taking into account:

D. the type, frequency, extent, and duration of treatment with scientifically based guidelines of national medical or health care coverage organizations or governmental agencies.
E. the level of service that can be safely and effectively furnished, and for which no equally effective and more conservative or less costly treatment is available.
F. that services are delivered in the setting that is clinically appropriate to the specific physical and mental/behavioral health care needs of the recipient.
G. that services are provided for medical or mental/behavioral reasons, rather than for the convenience of the recipient, the recipient's caregiver or the health care provider.

Medical necessity shall take into account the ability of the service to allow recipients to remain in a community-based setting, when such a setting is safe, and there is no less costly, more conservative, or more effective setting.

4. ☑ **Reevaluation Schedule**. *(By checking this box the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

5. ☑ **Needs-based HCBS Eligibility Criteria.** *(By checking this box the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

Children/youth must need minimum requirements to be considered for 1915(i) services:

1**. Impaired Functioning & Service Intensity**: The CM/WF and CFT will use a comprehensive biopsychosocial assessment and the level of care decision support tools the Early Childhood Service Intensity Instrument (ECSII) for youth ages 0-5 or the Child and Adolescent Service Intensity Instrument (CASII) for youth ages 6-18. The Wraparound Facilitator and CFT will review clinical indicators of impaired functioning: Prior psychological assessment records, prior placement history, and prior treatment history. Youth must demonstrate significant levels of behavioral health needs as evidenced by Serious Emotional Disturbance (SED) determination and must demonstrate a minimum CASII or ECSII level of 1.

AND

2. **Other Community Alternatives:** The accessibility and/or intensity of currently available community supports and services are inadequate to meet these needs due to the severity of the impairment without the provision of one or more of the services contained in the HCBS Benefit, as determined by the DCFS or its designee, as evidenced by at least one of the following risk factors:

- At risk of higher level of care placement due to recent placement disruption within the past six months;
- Current placement in emergency shelter or congregate care due to behavioral and mental health needs;
- In need of transition to community-based living arrangement with intensive behavioral supports when returning or stepping down from residential treatment center or other higher level of care placement; and/or
- At risk of higher level of care placement because prior traditional family foster care and/or less restrictive community treatment services have not been successful.

6. ☑ **Needs-based Institutional and Waiver Criteria.** *(By checking this box the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)
Children/youth must need minimum requirements to be considered for 1915(i) services: 1**. Impaired Functioning & Service Intensity**: The Wraparound Facilitator	The individual's condition requires services for three of the following: 1. Medication, 2. Treatment/Special Needs, 3. ADLs, 4. Supervision, or	In order to meet the ICF-IID level of care criteria, the individual must meet all of the following: 1. Have substantial functional impairments in three (3) or more of six (6) areas of major life activity (mobility,	The individual has chronic mental illness and has at least three functional deficits: 1. Imminent risk of self-harm, 2. Imminent risk of harm to others,

and CFT will use a comprehensive biopsychosocial assessment and the level of care decision support tools the Early Childhood Service Intensity Instrument (ECSII) for youth ages 0-5 or the Child and Adolescent Service Intensity Instrument (CASII) for youth ages 6-18. The Wraparound Facilitator and CFT will review clinical indicators of impaired functioning: Prior psychological assessment records, prior placement history, and prior treatment history. Youth must demonstrate significant levels of behavioral health needs as evidenced by Serious Emotional Disturbance (SED) determination and must demonstrate a minimum CASII or ECSII level of 1. AND 2. **Other Community Alternatives:** The accessibility and/or intensity of currently available community supports and services are inadequate to meet these needs due to the severity of the impairment without the provision of one or more of the services contained in the HCBS Benefit, as determined by the DCFS or its	5. IADLs.	selfcare, understanding and use of language, learning, self-direction, and capacity for independent living). For children age six years and younger, to have intensive support needs in areas of behavioral skills, general skills training, personal care, medical intervention, etc., beyond those required for children of the same age. 2. The individual has a diagnosis of an intellectual disability, or a related condition. The onset of an intellectual disability must have occurred before the age of 18, and the onset of a related condition must have occurred on or before age 22. 3. Must require monthly supports by, or under the supervision of, a health care professional or trained support personnel. 4. The monthly support may be from one entity or may be a combination of supports provided from various sources. 5. The individual cannot be maintained in a less restrictive environment without supports or services. Through the assessment process the team has identified the individual as being at	3. Risk of serious medical complications, or 4. Need for 24 hour supervision.

designee, as evidenced by at least one of the following risk factors: • At risk of higher level of care placement due to recent placement disruption within the past six months; • Current placement in emergency shelter or congregate care due to behavioral and mental health needs; • In need of transition to community-based living arrangement with intensive behavioral supports when returning or stepping down from residential treatment center or other higher level of care placement; and/or • At risk of higher level of care placement because prior traditional family foster care and/or less restrictive community treatment services have not been successful.		risk of needing institutional placement (ICF/IID) without the provision of at least monthly supports.	

*Long Term Care/Chronic Care Hospital

**LOC= level of care

7. ☑ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of five years. At least 90 days prior to the end of this five-year period, the state may request CMS renewal of this benefit for additional five-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

Target Group. Youth must meet all of the following:
- ✓ Youth must be under 19 years of age at the time of enrollment; they may continue in HCBS benefit through age 19
- ✓ and
- ✓ Youth must have a Diagnostic and Statistical Manual of Mental Disorders (DSM-5) or Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-3) diagnosis.

✓ **Option for Phase-in of Services and Eligibility** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. (Specify the phase-in plan):

(By checking the following box the State assures that):

8. ☑ **Adjustment Authority**. The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i) (1) (D) (ii).

9. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, <u>and</u> (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	**Minimum number of services**. The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is*:* 1	
ii.	**Frequency of services**. The state requires (select one):	
	●	**The provision of 1915(i) services at least monthly**
	○	**Monthly monitoring of the individual when services are furnished on a less than monthly basis** If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency:

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Home and Community-Based Settings

(By checking the following box the State assures that):

1. ☑ **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (*Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a) (1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):*

   (Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)

The State plan HCBS benefits will be furnished to children and young adults aged 0-18 who reside and receive HCBS in a home in the community, not in an institution. This may include residence in a home or apartment that is a licensed specialized foster care home. These settings are the private homes of foster parents or group homes who must meet a number of standard environmental and physical space dimensions of the home which are geared toward the individual needs of the children who live there. The child in the specialized foster care program will:

- Live in foster homes which are part of the community and close to provider services.
- Have a room(s) which meet the needs of the child from a physical and behavioral health perspective.
- Be free to move around in the home and is not restrained in any way.
- Be allowed to make life choices appropriate for the age of the child.
- If capable, assist in the selection of services and supports.
- Be in settings that can include additional foster care children and members of the foster family.
- Have some services provided directly in the foster home. Other services will occur in provider locations.

Person-Centered Planning & Service Delivery

(By checking the following boxes the state assures that):

1. ☑ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

2. ☑ Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

3. ☑ The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

4. Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities. There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):*

The CM/WF must be independent and both must have one of the following qualifications:

Qualified Mental Health Associate (QMHA) –
A person who meets the following documented minimum qualifications:

1. Licensure as a RN in the State of Nevada or holds a Bachelor's Degree from an accredited college or university in a human, social services or behavioral field with additional understanding of RMH treatment services and case file documentation requirements; or
2. Holds an associate's degree from an accredited college or university in a human, social services or behavioral field with additional understanding of RMH treatment services, and case file documentation and has four years of relevant professional experience of providing direct services to individuals with mental health disorders;
   or
3. An equivalent combination of education and experience as listed in1-2 above; and
4. Whose education and experience demonstrate the competency under clinical supervision to:
   a. Direct and provide professional therapeutic interventions within the scope of their practice and limits of their expertise;
   b. Identify presenting problem(s);
   c. Participate in treatment plan development and implementation;
   d. Coordinate treatment;
   e. Provide parenting skills training;
   f. Facilitate discharge plans; and
   g. Effectively provide verbal and written communication on behalf of the recipient to all involved parties.
5. Has a Federal Bureau of Investigation (FBI) background check in accordance with the Qualified Behavioral Aides (QBA) provider qualifications listed under Section 403.6A of the Nevada Medicaid Services Manual (MSM).

Qualified Mental Health Professional (QMHP) - A Physician, Physician's Assistant or a person who meets the definition of a QMHA and also meets the following documented minimum qualifications:

1. Holds any of the following educational degrees and licensure:

a. Doctorate degree in psychology and license;
b. Bachelor's degree in nursing and Advanced Practitioners of Nursing (APN) (psychiatry);
c. Independent Nurse Practitioner; Graduate degree in social work and clinical license;
d. Graduate degree in counseling and licensed as a marriage and family therapist or clinical professional counselor; or

2. Who is employed and determined by a state mental health agency to meet established class specification qualifications of a Mental Health Counselor; and
3. Whose education and experience demonstrate the competency to: identify precipitating events, conduct a comprehensive mental health assessment, diagnose a mental or emotional disorder and document a current ICD diagnosis, determine intensity of service's needs, establish measurable goals, objectives and discharge criteria, write and supervise a treatment plan and provide direct therapeutic treatment within the scope and limits of their expertise.

The following are also considered QMHPs:

a. Licensed Clinical Social Worker (LCSW) Interns meet the requirements under a program of internship and are licensed as an intern pursuant to the State of Nevada, Board of Examiners for Social Workers (Nevada Administrative Code (NAC) 641B).
b. Licensed Marriage and Family Therapist (LMFT) and Licensed Clinical Professional Counselor Interns who meet the requirements under a program of internship and are licensed as an intern pursuant to the State of Nevada Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors.
c. Psychological Assistants who hold a doctorate degree in psychology, are registered with the State of Nevada Board of Psychological Examiners (NAC 641.151) and are an applicant for licensure as a Licensed Clinical Psychologist who has not yet completed the required supervised postdoctoral experience approved by the Board.
d. Psychological Interns registered through the Psychological Board of Examiners defined in NAC 641.165. Interns must be supervised in accordance with state regulations and may only provide services within the scope of their licensure.

All Wraparound Facilitators will be required to be certified by DCFS as a Wraparound Facilitator utilizing the standards of the National Wraparound Implementation Center. All Care Managers will be required to be trained by DCFS in the FOCUS model utilizing the standards of the National Wraparound Implementation Center.

All Care Managers and Wraparound Facilitators will be at least QMHA level or above. All Care Managers and Wraparound Facilitators will be required to maintain appropriate certifications including certification on the Nevada Child and Adolescent Needs and Strengths tool (NV-CANS). Recipients will receive either services of CM or WF based on level of need.

5. **Responsibility for Development of Person-Centered Service Plan**. There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*

The development of the person-centered service plan will focus on a strengths and needs-driven approach that provides intensive care management in a team setting using a Child and Family Team (CFT) approach. The CFT team includes the CM/WF, child or youth, caregiver(s), support persons identified by the family (paid and unpaid), and service providers, including the youth's treating clinician as available.

The process is designed to promote youth and parent involvement as active members of the CFT. The goals of CFT meetings are to manage care and services to avoid fragmentation, ensure access to appropriate and person-centered care, and provide a team approach to address needs. Youth and parent/guardian involvement is essential in the assessment of: safety; strengths; medical, social, behavioral, educational and cultural needs; skill building; family/caregiver supports and services; and goals.

The CM/WF will utilize assessments to create the individualized POC for children and families. The plan will include needs, outcomes, and strategies that are:

- Specific. The CFT, including the family should know exactly what must be completed or changed and why.
- Measurable. Everyone should know when the needs have been met. Outcomes will be measurable to the extent that they are behaviorally based and written in clear and understandable language.
- Achievable. The CFT and family should be able meet the identified needs in a designated time period given the resources that are accessible and available to support change.

The person-centered POC will include detailed service plans for applicable 1915(i) services. The CFT shall develop the initial POC, which will be documented by the CM/WF. The CM/WF will also be responsible for documenting updates to the POC, including recommendations and decisions made by the CFT, in accordance to timeframes as listed in DCFS policy.

The CM/WF is responsible to submit the developed POC to the QIO-like vendor for approval.

6. **Supporting the Participant in Development of Person-Centered Service Plan**. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

The child's/youth's family is informed verbally and in writing about overall services available in the State Plan HCBS benefit at the time they make the choice to receive 1915(i) services. One of the key philosophies in the Wraparound process is family-driven care. This means that parent(s) or legal guardian, youth and family members are the primary decision makers in the care of their family. The CM/WF is responsible for working with the participant, family, and team to develop the Plan of Care through the process outlined below.

Within 72 hours of notification of enrollment, the CM/WF contacts the participant and family to schedule a face-to-face meeting. At the first meeting between the CM/WF, participant, and family after enrollment, the CM/WF will:

(a) Administer the appropriate assessments, as designated by DCFS;
(b) Work with the participant and family to develop an initial crisis plan that includes response to immediate service needs;
(c) Execute signing of releases of information and all necessary consents
(d) Provide an overview of the wraparound process; and
(e) Facilitate the family sharing their story.

The CM/WF will, with the participant and family: identify needs that they will work on in the planning process; determine who will attend team meetings; contact potential team members, provide them with an overview of the care management process, and discuss expectations for the first team meeting; conduct an initial assessment of strengths of the participant, their family members and potential team members; and, establish with the family their vision statement.

The team, which includes the participant and his or her family and informal and formal supports will determine the family vision which will guide the planning process; identify strengths of the entire team; be notified of the needs that the team will be working on; determine outcome statements for meeting identified needs; determine the specific services and supports required in order to achieve the goals identified in the POC; create a mission statement that the team generates and commits to following; identify the responsible person(s) for each of the strategies in the POC; review and update the crisis plan; and, meet at least every 30 days to coordinate the implementation of the POC and update the POC as necessary.

The plan must also address the methods used to ensure the active participation of the client and/or the legally responsible person and others to develop such goals and to identify the steps or actions each CFT member will take to respond to the assessed service needs of the participant. This will be demonstrated by the CFT members signing and dating the plan and any updates made to the plan during plan updates and reviews language.

The CM/WF in collaboration with the team shall reevaluate the POC at least every 90 days with re-administration of DCFS-approved assessments as appropriate.

7. **Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

All participants or legal guardians read and sign a "Statement of Understanding" form. The Statement of Understanding reads, "The 1915(i) HCBS are optional Nevada Medicaid services. Assessment of my diagnoses and needs will direct the services to be provided, as determined by the Child and Family Team led by the Care Manager or Wraparound Facilitator. I have the opportunity to participate as an active member of the Child and Family Team. The Child and Family team will support me in selecting providers for medically necessary HCBS services. My family and I, had a voice and choice in the selection of services, providers and interventions, when possible, in the FOCUS or Wraparound process of building my family's Plan of Care. I choose to receive HCBS. I understand that I have to be eligible for Medicaid to remain in this program. I have been offered a choice among applicable services and available providers." By signing this form participants acknowledge they have chosen from a list of available providers.

Provider enrollment into the program will not be limited; an ongoing enrollment of providers will promote choice and accessibility.

8. **Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency**. *(Describe the process by which the person-centered service plan is made subject to the approval of the Medicaid agency):*

DHCFP, through an Interlocal agreement with DCFS, delegates the responsibility for service plan approval to an independent contracted entity (QIO-like vendor). As part of its routine operations, DHCFP's contracted entity, must review each service plan submitted to ensure the plan addresses all pertinent issues identified through the assessment. The DHCFP contractor enters the determination of his/her review in the Provider Portal database. The Provider Portal database

interfaces with the Medicaid Management Information System for processing and tracking of eligible individuals, 1915(i) services and claims reimbursements. The DHCFP contractor informs DHCFP and DCFS of any issues related to the review and approval or denial of service plans. DHCFP retains the authority and oversight of the 1915(i) program delegated to DCFS. In addition, the [NAME] reviews and approves the policies, processes and standards for developing and approving the care plan.

Based on the terms and conditions of this State Plan Amendment, the Medicaid agency may review and overrule the approval or disapproval of any specific plan of care acted upon by DCFS serving in its capacity as the operating agency for the 1915(i) HCBS benefit program.

9. **Maintenance of Person-Centered Service Plan Forms**. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

☐	Medicaid agency	☑	Operating agency	☐	Case manager
☑	Other (*specify*):	Wraparound Process Contractor, DCFS			

Services

1. State plan HCBS. *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	**Intensive In-Home Supports and Services**
Service Definition (Scope):	
Intensive In-Home Supports and Services include: ✓ Evidence-based interventions that target emotional, cognitive, and behavioral functioning within a variety of actual and/or simulated social settings. Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence. Services focus on enabling the participant to attain or maintain his or her maximum potential and shall be coordinated with needed behavioral and physical health services and supports in the participant's person-centered services and support plans. ✓ Regular support and technical assistance to the treatment parents in their implementation of the POC and with regard to other responsibilities they undertake. The fundamental components of technical assistance are the design or revision of in-home treatment strategies including proactive goal setting and planning, the provision of ongoing child-specific skills training and the problem-solving during home visits. ✓ Assessing behavioral problems and the functions of these problems and related skill deficits and assets, including identifying primary and other important caregiver skill deficits and assets related to the youth's behaviors and the interactions that motivate, maintain, or improve behavior. Intensive In-Home Supports and Services may serve to reinforce skills, behaviors or lessons taught through other services.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	
N/A	
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*	
☑	Categorically needy *(specify limits):*

	The amount, frequency and duration of this service is based on the participant's assessed needs and documented in the approved POC. Eligible setting includes the child's home. Service Limitations: Intensive In-Home Services and Supports Without Coaching – Provided in-home by the treatment foster parent(s). Maximum of two hours per day, seven days a week. Service Limitations: Intensive In-Home Services and Supports With Coaching – Provided in-home by a trained coach supporting the treatment foster parent(s) to deliver evidence-based interventions to fidelity. Maximum of one hour per week.
☐	Medically needy *(specify limits):*
	N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Intensive Home-based provider/individual	Meet licensure requirements pursuant to DHCFP Medicaid Services Manual.	Service to be provided at a minimum by a Qualified Behavioral Aide (QBA) Certified in State evidence-based model.	Meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to DHCFP Medicaid Services Manual, Chapter 100. Meet all Conditions of Participation in Medicaid Services Manual 102.1.
Specialized Foster Care Agency	Pursuant to NRS 424, an application for a license to operate a foster care agency must be in a form prescribed by the Division and submitted to the appropriate licensing authority.	Service to be provided at a minimum by a Qualified Behavioral Assistant (QBA). Certified in State evidence-based model.	Meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to DHCFP Medicaid Services Manual, Chapter 100. Meet all Conditions of Participation in Medicaid Services Manual 102.1. Agencies must meet all applicable standards listed in NAC 424 and NRS 424.
Child Welfare Jurisdiction	Meet licensure requirements pursuant to DHCFP Medicaid Services Manual.	Service to be provided at a minimum by a QBA. Certified in State evidence-based model.	Meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to DHCFP Medicaid Services Manual, Chapters 100 and 400.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:		
Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Intensive Home-based provider	Administrating Agency – Division of Health Care Financing and Policy	Provider contract is effective for 60 months from enrollment date of its issuance and may be renewed upon expiration date.
Specialized Foster Care Agency	Operating Agency – Division of Child and Family Services	Pursuant to NRS 424, an application for a license to operate a foster care agency must be in a form prescribed by the Division and submitted to the appropriate licensing authority. Such a license is effective for 2 years after the date of its issuance and may be renewed upon expiration.
Child Welfare Jurisdiction	Administrating Agency – Division of Health Care Financing and Policy	Provider contract is effective for 60 months from enrollment date of its issuance and may be renewed upon expiration date.

Service Delivery Method. *(Check each that applies)*:			
☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	**Crisis Stabilization Services**
Service Definition (Scope)*:*	
Crisis Stabilization services are short-term, outcome-oriented, and of higher intensity than other behavioral interventions that are designed to provide interventions focused on developing effective behavioral management strategies to secure participant and family/caregiver's health and safety following a crisis. These services may only be delivered in an individual, one-to-one session and are available in the child's home. The service is short-term designed to achieve community stabilization through psychoeducation, crisis stabilization, and crisis resolution support. The service is of high intensity with the intent to develop effective behavioral strategies that will be maintained and help the child to sustain the behavioral strategies long-term.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	
N/A	

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑ Categorically needy *(specify limits):*

The amount, frequency and duration of this service is based on the participant's assessed needs and documented in the approved POC. This service is not subject to Prior Authorization requirements.

Crisis Stabilization services may only be delivered in an individual, one-to-one session and are available in the child/youth's home.

The maximum number of service hours per day is 4 hours for up to 40 hours per month. Post authorization request required beyond 40 hours. Additional units of services maybe authorized by DHCFP or designee on post authorization review.

☐ Medically needy *(specify limits):*

N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Specialized Foster Care Agency	Pursuant to NRS 424, an application for a license to operate a foster care agency must be in a form prescribed by the Division and submitted to the appropriate licensing authority.	QMHA under the direction of a QMHP; QMHP	Foster Care Agency providers must be enrolled as a Foster Care Provider Agency through DHCFP's fiscal agent and meet all required standards listed in the DHCFP Medicaid Services Manual. Agencies must meet all applicable standards listed in NAC 424 and NRS 424.
Child Welfare Jurisdiction	Meet licensure requirements pursuant to DHCFP Medicaid Services Manual.	QMHA under the direction of a QMHP; QMHP	Meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to DHCFP Medicaid Services Manual, Chapters 100 and 400.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:		
Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Specialized Foster Care Agency	Operating Agency – Division of Child and Family Services	Pursuant to NRS 424, an application for a license to operate a foster care agency must be in a form prescribed by the Division and submitted to the appropriate licensing authority. Such a license is effective for two years after the date of its issuance and may be renewed upon expiration.
Child Welfare Jurisdiction	Operating Agency – Division of Health Care Financing and Policy	Provider contract is effective for 60 months from enrollment date of its issuance and may be renewed upon expiration date.

Service Delivery Method. *(Check each that applies)*:			
☐	Participant-directed	☑	Provider managed

2. ☐ **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the state assures that):* There are policies pertaining to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i) (1) (G) (iii).

Election of Participant-Direction. (*Select one):*

●	The state does not offer opportunity for participant-direction of State plan HCBS.
○	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. *(Specify criteria):*

1. **Description of Participant-Direction. (Provide an overview of the opportunities for participant-** *direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

2. **Limited Implementation of Participant-Direction**. (*Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

○	Participant direction is available in all geographic areas in which State plan HCBS are available.
○	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the state affected by this option*):

3. **Participant-Directed Services**. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐

4. **Financial Management.** (*Select one)* :

●	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
○	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

5. ☐ **Participant–Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:

- Specifies the State plan HCBS that the individual will be responsible for directing;

- Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget;
- Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual;
- Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
- Specifies the financial management supports to be provided.

7. **Voluntary and Involuntary Termination of Participant-Direction.** *(Describe how the state facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

8. **Opportunities for Participant-Direction**

a. **Participant–Employer Authority** (individual can select, manage, and dismiss State plan HCBS providers). (*Select one):*

●	The state does not offer opportunity for participant-employer authority.	
○	Participants may elect participant-employer Authority *(Check each that applies):*	
	☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
	☐	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. **Participant–Budget Authority** (individual directs a budget that does not result in payment for medical assistance to the individual). (*Select one):*

●	The state does not offer opportunity for participants to direct a budget.
○	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):*

	Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.*

Quality Improvement Strategy

Quality Measures

(Describe the state's quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

1. Plan of Care a) address assessed needs of 1915(i) participants; b) are updated annually; and (c document choice of services and providers.

2. Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.

3. Providers meet required qualifications.

4. Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).

5. The SMA retains authority and responsibility for program operations and oversight.

6. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.

7. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation.

(Table repeats for each measure for each requirement and lettered sub-requirement above.)

Requirement	***1.a) Service plans address assessed needs of 1915(i) participants.***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of service plans reviewed that adequately address the assessed needs of 1915(i) participants. N = Number of service plans reviewed that adequately address the assessed needs of 1915(i) participants. D = Total number of service plans reviewed.
Discovery Activity *(Source of Data & sample size)*	Record reviews, on-site. Less than 100% review. The State will obtain a sample size that will produce a probability of 95% and confidence level of 5% using Raosoft Sample Size Calculator.
Monitoring Responsibilities	State Medicaid Agency (SMA) Quality Assurance (QA) and 1915(i) Units.

	(Agency or entity that conducts discovery activities)	
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA and operating agency will remediate any issue or non-compliance within 30 days. Deficiencies are remediated through the monthly quality improvement (QI) meeting. The QI team consists of SMA QA and 1915(i) Units.
	Frequency *(of Analysis and Aggregation)*	Monthly, Quarterly, Annually

Requirement		***1.b) Service plans are updated annually***
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of service plans that are updated at least once in the last 12 months. N = Number of service plans that are updated at least once in the last 12 months. D = Total number of service plans reviewed.
	Discovery Activity *(Source of Data & sample size)*	Record reviews, on-site. Less than 100% Review. The State will obtain a sample size that will produce a probability of 95% and confidence level of 5% using Raosoft Sample Size Calculator.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA and operating agency QA Unit
	Frequency	Annually
Remediation		

	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA and operating agency will remediate any issue or non-compliance within 30 days. Deficiencies are remediated through the monthly quality improvement (QI) meeting. The QI team consists of SMA QA and 1915(i) Units.
	Frequency *(of Analysis and Aggregation)*	Monthly, Quarterly, and Annually

Requirement		***1.c) Service plans document choice of services and providers***
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of service plans reviewed that indicate 1915(i) participants were given a choice when selecting services. N = Number of service plans reviewed that indicate 1915(i) participants were given a choice when selecting services. D = Total number of service plans reviewed
	Discovery Activity *(Source of Data & sample size)*	Record reviews, on-site. Less than 100% Review. The State will obtain a sample size that will produce a probability of 95% and confidence level of 5% using Raosoft Sample Size Calculator.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA and operating agency QA Unit
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation*	SMA and operating agency will remediate any issue or non-compliance within 30 days. Deficiencies are remediated through the monthly quality improvement (QI) meeting. The QI team consists of SMA QA and 1915(i) Units.

activities; required timeframes for remediation)	
Frequency *(of Analysis and Aggregation)*	Monthly, Quarterly, and Annually

Discovery Evidence *(Performance Measure)*	Number and percent of service plans reviewed that indicate 1915(i) participants were given a choice when selecting providers. N = Number of service plans reviewed that indicate 1915(i) participants were given a choice when selecting providers. D = Total number of service plans reviewed
Discovery Activity *(Source of Data & sample size)*	Record reviews, on-site. Less than 100% Review. The State will obtain a sample size that will produce a probability of 95% and confidence level of 5% using Raosoft Sample Size Calculator.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA and operating QA Unit
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA will remediate any issue or non-compliance within 30 days. Deficiencies are remediated through the monthly quality improvement (QI) meeting. The QI team consists of SMA QA and 1915(i) Units.
Frequency *(of Analysis and Aggregation)*	Monthly, Quarterly, and Annually

Requirement	**2. (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of new applicants who had an evaluation indicating the individual met the 1915(i) needs-based eligibility criteria prior to receiving services. N: Number of new applicants who had an evaluation indicating the individual met the 1915(i) needs-based eligibility criteria prior to receiving services. D: Number of new applicants receiving 1915(i) services reviewed.
Discovery Activity *(Source of Data & sample size)*	Record reviews, on-site. Less than 100% Review. The State will obtain a sample size that will produce a probability of 95% and confidence level of 5% using Raosoft Sample Size Calculator.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA 1915(i) Unit and operating agency
Frequency	Monthly, Quarterly and Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA and operating will remediate any issue or non-compliance within 30 days. Deficiencies are remediated through the monthly quality improvement (QI) meeting. The QI team consists of SMA QA and 1915(i) Units.
Frequency *(of Analysis and Aggregation)*	Quarterly, Annually

Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of applicants who receive an evaluation for 1915(i) State plan HCBS eligibility for whom there is reasonable indication that 1915(i) services may be needed in the future. N: Number of applicants who receive an evaluation for 1915(i) State plan HCBS eligibility for whom there is reasonable indication that 1915(i) services may be needed in the future.

	D: Number of 1915(i) applicants
Discovery Activity *(Source of Data & sample size)*	Record reviews, on-site. Less than 100% Review. The State will obtain a sample size that will produce a probability of 95% and confidence level of 5% using Raosoft Sample Size Calculator.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA 1915(i) Unit and operating agency
Frequency	Monthly, Quarterly and Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA will remediate any issue or non-compliance within 30 days. Deficiencies are remediated through the monthly quality improvement (QI) meeting. The QI team consists of SMA QA and 1915(i) Units.
Frequency *(of Analysis and Aggregation)*	Quarterly, Annually

Requirement	**2. (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of reviewed 1915(i) evaluations that were completed using the processes and instruments approved in the 1915(i) HCBS state plan. N = Number of reviewed 1915(i) evaluations that were completed using the processes and instruments approved in the 1915(i) HCBS state plan. D = Total number of 1915(i) evaluations reviewed
Discovery Activity	Record reviews, on-site. Less than 100% Review. The State will obtain a sample size that will produce a probability of 95% and confidence level of 5% using Raosoft Sample Size Calculator.

	(Source of Data & sample size)	
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA and operating agency Quality Assurance
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA and operating agency is responsible for the collection of documentation of monitoring findings, remediation, analysis of effectiveness of remediation, documentation of system improvement. Documentation of sample selection process for program review, monitoring tools, monitoring findings reports and management reports. SMA and operating agency will remediate any issue or non-compliance within 30 days. Deficiencies are remediated through the monthly quality improvement (QI) meeting. The QI team consists of SMA QA and 1915(i) Units.
	Frequency *(of Analysis and Aggregation)*	Monthly, Quarterly and Annually

Requirement		**2. (c) the 1915(i)-benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS**
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percentage of enrolled recipients whose 1915 (i) benefit Needs Based eligibility Criteria, was reevaluated annually. N: Number of enrolled recipients whose Needs Based Criteria was reevaluated annually; D: Number of enrolled recipients reviewed.
	Discovery Activity *(Source of Data & sample size)*	Record reviews, on-site. 100% Review
	Monitoring Responsibilities *(Agency or entity that conducts*	SMA QA

	discovery activities)	
	Frequency	Quarterly, Annually, Continuously and Ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA and operating agency will remediate any issue or non-compliance within 30 days. Deficiencies are remediated through the monthly quality improvement (QI) meeting. The QI team consists of SMA QA and 1915(i) Units.
	Frequency *(of Analysis and Aggregation)*	Quarterly, Annually, Continuously and Ongoing

Requirement		**Providers meet required qualifications.**
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of 1915(i) providers who meet the State's certification standards, as required, prior to providing 1915(i) services. N: Number of 1915(i) providers who meet the State's certification standards, as required, prior to providing 1915(i) services. D: Total number of 1915(i) providers reviewed.
	Discovery Activity *(Source of Data & sample size)*	Record reviews. 100% Review
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA 1915(i) Unit, Provider Enrollment Unit and SMA Fiscal Agent and operating agency
	Frequency	Annually
Remediation		

Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA 1915(I), and Provider Enrollment Units and Fiscal Agent. State Medicaid Agency will remediate any issue or non-compliance within 30 days. All provider enrollment applications and revalidations are submitted electronically through the Interchange. The Fiscal Agent and SMA Provider Enrollment Unit monitor and review all applications and documents and make appropriate action as needed.
Frequency *(of Analysis and Aggregation)*	Ongoing and Annually or on re-validation schedule

Requirement	**4. Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of HCBS settings that meet Federal HCBS settings requirements. N: Number of HCBS settings that meet Federal HCBS settings requirements. D: Total # of HCBS settings providing 1915(i) services.
Discovery Activity *(Source of Data & sample size)*	Record reviews, on-site. 100% Review. The State will obtain a sample size that will produce a probability of 95% and confidence level of 5% using Raosoft Sample Size Calculator.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA QA
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities;*	State Medicaid Agency and operating agency will remediate any issue or non-compliance within 30 days. Deficiencies are remediated through the monthly quality improvement (QI) meeting. The QI team consists of SMA QA and 1915(i) Units.

	required timeframes for remediation)	
	Frequency *(of Analysis and Aggregation)*	Annually

Requirement		**5. The SMA retains authority and responsibility for program operations and oversight.**
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of issues identified in contract monitoring reports that were remediated as required by the state. N = Number of issues identified in contract monitoring reports that were remediated as required by the State. D = Total number of issues identified.
	Discovery Activity *(Source of Data & sample size)*	Provider application. Less than 100% Review. The State will obtain a sample size that will produce a probability of 95% and confidence level of 5% using Raosoft Sample Size Calculator.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA 1915(i) Unit.
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA will remediate any issue or non-compliance within 30 days. On a monthly basis, HCC supervisor reviews random sample of case files and if deficiencies are found, will take action as needed through one-on-one education with the HCC as well as remediation discussion during the monthly QI meeting.
	Frequency *(of Analysis and Aggregation)*	Annually taken from the monthly analysis

Requirement	**6. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of claims paid to 1915(i) service providers who are qualified to furnish 1915(i) services to 1915(i) recipients. N: Number of claims paid to 1915(i) service providers who are qualified to furnish 1915(i) services to 1915(i) recipients. D: Number of claims reviewed.
Discovery Activity *(Source of Data & sample size)*	Financial records (including expenditures); Less than 100% Review. The State will obtain a sample size that will produce a probability of 95% and confidence level of 5% using Raosoft Sample Size Calculator.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA QA
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA will remediate any issue or non-compliance within 30 days. Deficiencies are remediated through the monthly quality improvement (QI) meeting. The QI team consists of SMA QA and 1915(i) units.
Frequency *(of Analysis and Aggregation)*	Monthly, Quarterly, Annually

Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of claims verified through a review of provider documentation that have been paid in accordance with the individual's service plan. N: Number of claims verified through a review of provider documentation that have been paid in accordance with the individual's service plan. D: Total number of claims reviewed.

	Discovery Activity *(Source of Data & sample size)*	Financial records (including expenditures); Less than 100% Review. The State will obtain a sample size that will produce a probability of 95% and confidence level of 5% using Raosoft Sample Size Calculator.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA QA
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA will remediate any issue or non-compliance within 30 days. Deficiencies are remediated through the monthly quality improvement (QI) meeting. The QI team consists of SMA QA and 1915(i) Units.
	Frequency *(of Analysis and Aggregation)*	Monthly, Quarterly, Annually

Requirement		**7. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation.**
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of 1915(i) recipients who receive information/education about how to report abuse, neglect, exploitation and other critical incidents. N: Number of recipients who received information or education about how to report abuse, neglect, exploitation and other critical incidents. D: Number of participants reviewed.
	Discovery Activity *(Source of Data & sample size)*	Records review on-site, 100% Review.
	Monitoring Responsibilities	SMA

	(Agency or entity that conducts discovery activities)	
	Frequency	Annually, Continuously and Ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA will remediate any issue or non-compliance within 30 days. During initial and annual assessment, potential recipient/recipient will be educated and sign the acknowledgement form indicating they were given information on how report and provided a list of contacts for reporting critical incidence. The form will be kept in the case file for 1915(i) supervisor review monthly and for SMA QA review annually.
	Frequency *(of Analysis and Aggregation)*	Monthly, Quarterly, Annually

Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of incident reviews/investigations that were initiated regarding unexplained deaths, abuse, neglect, exploitation and unapproved restraints as required by the SMA. N: Number of incident reviews/investigations that were initiated regarding unexplained deaths, abuse, neglect, exploitation and unapproved restraints as required by the SMA. D: Number of incidents reviewed.
	Discovery Activity *(Source of Data & sample size)*	Records review on-site, 100% Review.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA
	Frequency	Annually, Continuously and Ongoing
Remediation		

	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA will remediate any issue or non-compliance within 30 days. All Serious Occurrence Reports (SOR) must be reported within 24 hours of discovery. All SORs are entered into the database called Harmony, including follow-ups by HCCs. On a weekly basis or as needed, HCC supervisor reviews and approves follow-ups to ensure appropriate action is taken and the health and safety of the recipients have been addressed timely. Reports are generated upon request. Within five business days, HCC will conduct all necessary follow-ups to include plan of correction, report submitted to law enforcement, EPS or Health Care Quality and Compliance (HCQC) if applicable. The Harmony database monitors and tracks all incidents and generates reports upon request. The 1915(i) Supervisor will review SORs on a weekly or as needed basis.
	Frequency *(of Analysis and Aggregation)*	Monthly, Quarterly, Annually

Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of incident reviews/investigations involving unexplained deaths, abuse, neglect, exploitation and unapproved restraints for recipients that were completed by the SMA. N: Number of incident reviews/investigations involving unexplained deaths, abuse, neglect, exploitation and unapproved restraints for recipients that were completed by the SMA. D: Number of incidents reviewed.
	Discovery Activity *(Source of Data & sample size)*	Records review on-site, 100% Review.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA
	Frequency	Annually, Continuously and Ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and*	SMA will remediate any issue or non-compliance within 30 days. All Serious Occurrence Reports (SOR) must be reported within 24 hours of discovery. All SORs are entered into the database called Harmony, including

	aggregates remediation activities; required timeframes for remediation)	follow-ups by HCCs. On a weekly basis or as needed, HCC supervisor reviews and approves follow-ups to ensure appropriate action is taken and the health and safety of the recipients have been addressed timely. Reports are generated upon request. Within 5 business days, 1915(i) HCC will conduct all necessary follow-ups to include plan of correction, report submitted to law enforcement, EPS or Health Care Quality and Compliance (HCQC) if applicable. The Harmony database monitors and tracks all incidents and generates reports upon request. The 1915(i) Supervisor will review SORs on a weekly or as needed basis.
	Frequency *(of Analysis and Aggregation)*	Monthly, Quarterly, Annually

Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of incidents reviewed involving abuse, neglect, exploitation, unexplained deaths, and unapproved restraints that had a plan of prevention/documentation of a plan developed as a result of the incident. N: Number of incidents reviewed involving abuse, neglect, exploitation, unexplained deaths, and unapproved restraints that had a plan of prevention/documentation of a plan developed as a result of the incident. D: Number of incidents reviewed.
	Discovery Activity *(Source of Data & sample size)*	Records review on-site, 100% Review.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA
	Frequency	Annually, Continuously and Ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required*	SMA will remediate any issue or non-compliance within 30 days. All Serious Occurrence Reports (SOR) must be reported within 24 hours of discovery. All SORs are entered into the database called Harmony, including follow-ups by HCCs. On a weekly basis or as needed, HCC supervisor reviews and approves follow-ups to ensure appropriate action is taken and the health and safety of the recipients have been addressed timely. Reports are generated upon request.

	timeframes for remediation)	Within 5 business days, the 1915(i) HCC will conduct all necessary follow-ups to include plan of correction, report submitted to law enforcement, EPS or Health Care Quality and Compliance (HCQC) if applicable. The Harmony database monitors and tracks all incidents and generates reports upon request. The 1915(i) Supervisor will review SORs on a weekly or as needed basis.
	Frequency *(of Analysis and Aggregation)*	Monthly, Quarterly, Annually

System Improvement
(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. Methods for Analyzing Data and Prioritizing Need for System Improvement

On an ongoing basis, the 1915(i) and QA Units collaborate in a Quality Improvement Team to assess quality improvements needed to ensure required performance measures are met. Monthly Comprehensive QI meetings review performance measures below 86% to determine remediation and mitigation efforts using CMS guidelines. Such guidelines include, but are not limited to, identifying probable cause, development of interventions to improve performances, trend analysis on performance measures, etc. On an as needed basis, the QA Unit conducts educational trainings with the 1915(i) Unit regarding how to perform case file and provider reviews. Provider reviews are entered into the ALis database to be tracked and deficiencies flagged. Depending on the deficiency, referrals are sent to an appropriate state agency for review and corrective action plan as appropriate.

Case Management records are in a SAMS database which generates reports needed for QA case file reviews. Provider records are managed through the InterChange (Medicaid Management Information System) and reviewed by the SMA Fiscal Agent and Provider Enrollment Unit. Electronic submission of claims is also done through InterChange, which has built-in edits to ensure claims are processed correctly and appropriately.

Serious Occurrence Reports (SORs) are tracked through a Harmony system which is monitored and reviewed by the 1915(i) Supervisor.

2. Roles and Responsibilities

The SMA QA complete annual reviews of the performance measures outlined above excluding provider reviews which are conducted by the 1915(i) Unit.

1915(i) and QA Unit participate in monthly and quarterly comprehensive QI meetings.

3. Frequency

QI Team meet monthly to discuss remediations on deficiencies found during the annual review. QI Team also meet quarterly to review remediations and discuss system improvement to determine changes as needed to the process. The QIS is evaluated in its entirety prior to the 5-year renewal.

4. Method for Evaluating Effectiveness of System Changes

Through QI Team meetings, trend analysis is conducted on remediation efforts to determine effectiveness of such efforts and those performance measures needing continual improvement. As potential trends develop, specific activities will be identified that may need changing and an evaluation is conducted to remedy the issue.

Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates)*:

☐	HCBS Case Management	
☐	HCBS Homemaker	
☐	HCBS Home Health Aide	
☐	HCBS Personal Care	
☐	HCBS Adult Day Health	
☐	HCBS Habilitation	
☐	HCBS Respite Care	
For Individuals with Chronic Mental Illness, the following services:		
	☐	HCBS Day Treatment or Other Partial Hospitalization Services
	☐	HCBS Psychosocial Rehabilitation
	☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
☑	Other Services (specify below)	
	Crisis Stabilization Services –	
	Intensive In-home services and supports -	

A. Reimbursement Methodology for Home and Community Based Services provided by a state or local government entity

Home and Community Based Services provided by a state or local government entity are reimbursed according to a methodology used to certify costs as representing expenditures eligible for FFP and may be used only by providers who undergo all Medicaid cost identification, reporting, reconciliation and settlement procedures.

The lower of: a) billed charges; or b) an interim rate. The Interim rate is the rate for a specific service for a period that is provisional in nature, pending the completion of cost reconciliation and a cost settlement for that period.

To determine the Medicaid-allowable direct and indirect costs of providing Home and Community Based Services the following steps are performed:

1. Interim Rates

Governmental providers are reimbursed on an interim basis for direct medical services per unit of service at the lesser of the provider's billed charges or a provider-specific interim rate. A provider-specific interim rate is an annual rate for the specific services for a period that is provisional in nature, pending the completion of cost reconciliation and a cost settlement for that period. Interim rates are based on program experience and cost data reported during the prior fiscal year.

2. Annual Cost Report Process

Each governmental provider will complete an annual cost report in the format proscribed by Nevada Medicaid in the Medicaid Operations Manual for all medical services delivered during the previous state fiscal year covering July 1 through June 30. The cost report is due on or before December 1 of the year following the close of the reporting period.

The primary purposes of the cost report are to:

a. document the provider's total Medicaid-allowable cost for delivering the medical services, including direct costs and indirect costs, based on the methodologies/steps described below.

b. reconcile its interim payments to its total Medicaid-allowable costs.

The annual Medicaid Cost Report includes a certification of funds statement to be completed, certifying the provider's actual, incurred allocable and allowable costs/expenditures. All filed annual Cost Reports are subject to audit by DCHFP or its designee.

To determine the Medicaid-allowable direct and indirect costs of providing covered services to Medicaid-eligible clients, the following steps are performed:

1. Facilities that are primarily providing medical Services:

   a. Direct costs for covered services include unallocated payroll costs and other unallocated costs that can be directly charged to covered medical services. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct care staff. Other direct costs include costs directly related to the delivery of covered services, such as supervision, materials and supplies, professional and contracted services, capital outlay, and travel. These costs must be in compliance with Medicaid non-institutional reimbursement policy and are accumulated on the annual cost report, resulting in total direct costs.

   b. Total direct costs from Item (a) are reduced by any amount that is not in compliance with Medicaid non-institutional reimbursement policy and are further reduced by any federal payments for those costs, resulting in adjusted direct costs for covered services.

   c. Indirect costs are determined by applying the agency specific approved indirect cost rate to its net direct costs. If the provider has no approved indirect cost rate, the allocated indirect costs can be derived from the allocation process through the provider's approved cost allocation plan. These allocated indirect costs are reduced by any unallowable amount based on Medicaid non-institutional reimbursement policy. The indirect costs details are accumulated on the annual cost report.

   d. Net direct costs (Item b) and indirect costs (Item c) are combined.

   e. A CMS approved time study is required when providers of service do not spend 100% of their time providing the Medical services described in the applicable Section 3.1-A State Plan pages and is used to determine the percentage of time that medical service personnel spend on direct medical services, general and administrative time, and all other activities to account for 100% of the time to assure that there is no duplicate claiming. This CMS approved time study methodology will be used to separate administrative activities and direct services. The direct medical services time study percentage is applied against the net direct and indirect costs.

   f. Medicaid's portion of total allowable costs is calculated by multiplying the result from Item (e) above to the ratio of the total units

of service provided to Medicaid eligible clients to the total units of service provided.

g. Total Medicaid allowable costs (Item f) is reduced by any revenue, e.g. Medicaid co-payments, TPL, received for the same services to arrive at the total Medicaid net allocable and allowable costs.

2. Facilities that are used for multiple purposes and the provision of medical services are not the primary purpose:

a. Direct costs include unallocated payroll costs and medical equipment and supplies. Unallocated payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct care staff. These costs are accumulated on the annual cost report.

b. The Direct costs from Item (a) are reduced by any amount that is not in compliance with Medicaid non-institutional reimbursement policy and are further reduced by any federal payments for those costs, resulting in adjusted direct costs.

c. Indirect costs are determined by applying the agency specific approved indirect cost rate to its net direct costs (Item b.). If the entity has no approved indirect cost rate, the allocated indirect costs can be derived from the allocation process through the provider's approved cost allocation plan. These indirect costs are reduced by any unallowable amount. For these facilities, allowable costs are only those cost that are "directly attributable" to the professional component of providing the medical services and are in compliance with Medicaid non-institutional reimbursement policy. For those costs incurred that "benefit" multiple purposes but would be incurred at the same level if the medical services did not occur are not allowed, e.g. room and board, allocated cost from other related organizations. The indirect cost details are accumulated on the annual cost report.

d. Net direct costs (Item (b)) and indirect costs (Item (c)) are combined.

e. A CMS approved time study is required when providers of service do not spend 100% of their time providing the Medical services described in the applicable Section 3.1-A State Plan pages and is used to determine the percentage of time that medical service personnel spend on direct medical services, general and administrative time, and all other activities to account for 100% of the time to assure that there is no duplicate claiming. This CMS approved time study methodology will be used to separate administrative activities and direct services.

The direct medical services time study percentage is applied against the net direct and indirect costs.

f. Medicaid's portion of the total net allocable and allowable costs is calculated by multiplying the result from Item (e) above to the ratio of total units of service provided to Medicaid eligible clients to the total units of service provided.

g. Total Medicaid allowable costs (Item f) is reduced by any revenue received for the same services, e.g. Medicaid co-payments and TPL, to arrive at the total Medicaid net

h. allocable and allowable costs.

3. Cost Reconciliation Process

Governmental providers will be responsible for reconciling total allowable computable costs reported on the cost report to the provider's Medicaid interim payments for Medicaid services delivered during the reporting period as document in the MMIS, resulting in cost reconciliation. The cost reconciliation process must be completed within 24-months of the end of the reporting period covered by the annual Cost Report.

4. Cost Settlement Process

If a governmental provider's interim payments exceed the actual, certified costs of the provider for services to Medicaid clients, the DHCFP will recoup the federal share of the overpayment using one of the following two methods:

a. Off-set all future claims payments from the provider until the amount of the federal share of the overpayment is recovered;

b. The provider will return an amount equal to the overpayment.

If the actual, certified costs exceed the interim Medicaid payments, the DHCFP will pay the federal share of the difference to the provider in accordance with the final actual certification agreement.

The DHCFP will issue a notice of settlement that denotes the amount due to or from the provider.

B. Reimbursement Methodology for Home and Community Based Services provided by non-governmental entities and governmental entities who do not undergo the Medicaid cost identification and reporting procedures:

1. Home and Community Based Services:

- Crisis Stabilization Services: 1 unit per 15 minutes*
- Intensive In-Home Services and Supports – with coaching: 1 unit per 15 minutes*
- Intensive In-Home Services and Supports – without coaching: 1 unit per 15 minutes*

  Services noted above provided by private entities or governmental entities that do not undergo the Medicaid cost identification and reporting procedures will be reimbursed on a statewide fee schedule.

Rate Methodology:

The rates are market based. This model is developed to reflect service definitions, provider requirements, operational service delivery and administrative considerations. The following elements are used to determine the rates:

- Wage information is derived from the Bureau of Labor Statistics (BLS). The wage is based on similar occupations reported by BLS and identified by Medicaid staff as comparable to services provided under the Home and Community Based Services program.
- Employee-related expenses (ERE) are calculated at 27% of the wages described above. This percentage aligns with the ERE factor applied for non-residential mental health rehabilitation services, which was determined from input from a Task Force and research conducted by Medicaid Staff. ERE includes paid vacation, paid sick leave, holiday pay, health insurance, life insurance, disability, workers compensation and legally required payroll taxes.
- A productivity adjustment factor was applied, which accounts for the amount of non-billable time spent by staff. This includes the time staff needs to complete required documentation and record keeping, time associated with missed appointments and average travel time by the provider.
- Allowance for supervisory time – costs for the time directly spent in supervising the individual providing these services (this does not apply to Intensive In-Home Supports Without Coaching).
- Mileage costs are included for Intensive In-Home Supports (With Coaching) and In-Home Crisis Stabilization. The estimated number of miles was multiplied by the IRS Standard Mileage Rate for 2019.
- Administrative overhead (15%) is the percentage of service costs that should result from non-direct care activities. It includes insurance, administrative staff, operations and management activities, and office supplies. Capital and related expenses, along with staff training, are not included.

The following steps are used to determine the rates:

1. The State will use Nevada-specific hourly wages from the Bureau of Labor Statistics.

2. The hourly amount is increased by the 27% ERE.

3. A productivity adjustment factor is applied to the hourly compensation calculated in Item 2 to equal the hourly rate.

4. The adjusted hourly rate per individual is the hourly rate per individual (Item 3) increased by the allowance amounts for supervisory time and mileage calculations (this step excludes Intensive In-Home Supports Without Coaching).

5. Administrative overhead (15%) is applied to the adjusted hourly rate per individual (Item 4).

6. The total hourly rate is the sum of the adjusted hourly rate per individual before administrative overhead (Item 4) and the administrative overhead (Item 5).

7. Total hourly rate is scaled to the proper unit based on the unit of service.

Groups Covered

Optional Groups other than the Medically Needy

In addition to providing State plan HCBS to individuals described in 1915(i)(1), the state may **also** cover the optional categorically needy eligibility group of individuals described in 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the FPL, or who are eligible for HCBS under a waiver approved for the state under Section 1915(c), (d) or (e) or Section 1115 (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate. See 42 CFR § 435.219. (*Select one*):

☑ No. Does not apply. State does not cover optional categorically needy groups.

☐ Yes. State covers the following optional categorically needy groups. *(Select all that apply):*

(a) ☐ Individuals not otherwise eligible for Medicaid who meet the needs-based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services. There is no resource test for this group. Methodology used: *(Select one):*

☐ SSI. The state uses the following less restrictive 1902(r)(2) income disregards for this group. (*Describe, if any*):

☐ OTHER (*describe*):

(b) ☐ Individuals who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d) or (e) (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate.
Income limit: (*Select one):*

☐ 300% of the SSI/FBR

☐ Less than 300% of the SSI/FBR (*Specify):* _____%

Specify the applicable 1915(c), (d), or (e) waiver or waivers for which these individuals would be eligible: *(Specify waiver name(s) and number(s)):*

(c) ☐ Individuals eligible for 1915(c), (d) or (e) -like services under an approved 1115 waiver. The income and resource standards and methodologies are the same as the applicable approved 1115 waiver.

Specify the 1115 waiver demonstration or demonstrations for which these individuals would be eligible. *(Specify demonstration name(s) and number(s)):*

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