Table of Contents

State/Territory Name: Nevada

State Plan Amendment (SPA) #: 24-0024

This file contains the following documents in the order listed:

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

October 28, 2024

Stacie Weeks, Administrator
Nevada Department of Health and Human Services
Division of Health Care Financing and Policy
1100 E. Williams Street, Suite101
Carson City, NV 89701

RE: Transmittal Number 24-0024 §1915(i) home and community-based services (HCBS) state plan amendment (SPA)

Dear Stacie Weeks:

The Centers for Medicare & Medicaid Services (CMS) is approving the state's 1915(i) state plan home and community-based services (HCBS) state plan amendment (SPA), transmittal number TN# 24-0024. The purpose of this amendment is to renew Nevada's 1915(i) State Plan HCBS benefit; to identify additional individuals qualified to perform 1915(i) evaluations reevaluations of eligibility, to perform the independent assessment of needs, and to develop the person-centered service plan; and to clarify performance measures within the quality improvement strategy The effective date for this renewal is March 1, 2025. Enclosed is a copy of the approved SPA.

Since the state has elected to target the population who can receive these §1915(i) State Plan HCBS, CMS approves this SPA for a five-year period expiring February 28, 2030, 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 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 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 SPA. The evidence must include data analysis, findings, remediation, and describe any system improvement for each of the §1915(i) requirements.

CMS reminds the state that the state must have an approved spending plan in order to use the money realized from section 9817 of the ARP. Approval of this action does not constitute approval of the state's spending plan.

It is important to note that CMS' approval of this 1915(i) HCBS state plan benefit renewal 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, Section 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 (410) 786-7561. You may also contact Kathleen Creggett at Kathleen.Creggett@cms.hhs.gov or (415) 744-3656.

Sincerely,

[redacted] y signed by George
a Jr -S
2024.10.28
53 -04'00'

George P. Failla, Jr., Director
Division of HCBS Operations and Oversight

Enclosure
cc: Deanna Clark, CMCS
Blake Holt, CMCS, CMS

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: 24-0024

2. STATE: NV

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
March 01, 2025

5. FEDERAL STATUTE/REGULATION CITATION
Section 1915(i) of Title XIX Social Security Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2025 $ 0
b. FFY 2026 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-i-1
Attachment 4.19-B page 14 through 14g
~~Attachment 2.2-A page 28 through 29~~

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-i-1
Attachment 4.19-B page 14 through 14g
~~Attachment 2.2-A page 28 through 29~~

9. SUBJECT OF AMENDMENT
Renewal of the 1915(i) Home and Community Based Services (HCBS) State Plan Option for Adult Day Health Care and Habilitation Services.

10. 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:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
RICHARD WHITLEY

13. TITLE
DIRECTOR, DHHS

14. DATE SUBMITTED
July 31, 2024

15. RETURN TO
Cynthia Leech, Compliance Agency Manager
DHCFP/Medicaid
1100 East William Street, Suite 101
Carson City, NV 89701

FOR CMS USE ONLY

16. DATE RECEIVED
August 1, 2024

17. DATE APPROVED
October 28, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
October 28, 2024

19. SIGNATURE OF APPROVING OFFICIAL
George P. Failla Jr -S
Digitally signed by George P. Failla Jr -S
Date: 2024.10.28 17:05:32 -04'00'

20. TYPED NAME OF APPROVING OFFICIAL
George P. Failla, Jr.

21. TITLE OF APPROVING OFFICIAL
Division Director

22. REMARKS

State edits made to 3.1-i-1 pgs 1-35 to update qualification process of individuals conducting assessments, needs-based criteria, the person-centered service plan and applicable quality system improvements; in addition to 4.19b pgs 14-14g financial edits for medical care and services and covered groups.

SPA pages 2.2-A pages 28-29 are not a part of this renewal.

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):*

NEVADA 1915(i) STATE PLAN HOME AND COMMUNITY BASED SERVICES–
Adult Day Health Care, Day Habilitation and Residential Habilitation.

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)*:	Division of Health Care Financing and Policy
	○	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)*		
	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):

The Contracted Entity is the Nevada SMA Fiscal Agent.

(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 ensures, 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
Year 1	03/1/2025	02/28/2026	1800

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 State Medicaid Agency
	By Other (*specify State agency or entity under contract with the State Medicaid 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):*

SMA Health Care Coordinator (HCC) or SMA designated representative (which include SMA Policy Specialists or SMA Program Supervisors), licensed as a Social Worker by the State of Nevada Board of Examiners for Social Workers; licensed as a Registered Nurse by the Nevada State Board of Nursing; or with a professional license or certificate in a medical specialty applicable to the assignment are qualified to perform the evaluation and reevaluation of 1915(i) eligibility. Additional Criteria includes valid driver's license to enable site and home visits, adhere to Health Insurance Portability and Accountability Act (HIPAA) requirements and FBI Criminal History Background Check (standard for all State employees).

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:

SMA Health Care Coordinator (HCC) or SMA designated representative conducts a face-to-face visit with a potential recipient to determine whether the needs-based criteria will be met. The face-to-face assessment may be performed by telemedicine, when the following conditions are met:

- The agent performing the assessment is independent and qualified and meets the provider qualifications defined by the State, including any additional qualifications or training requirements for the operation of required information technology;
- The individual receives appropriate support during the assessment, including the use of any necessary on-site support staff; and
- The individual provides informed consent for this type of assessment.

Prior to contacting the individual to schedule their assessment, the SMA verifies with the Division of Welfare and Supportive Services system that the individual meets Medicaid eligibility. The Health Care Coordinator or SMA designated representative uses the Comprehensive Social Health Assessment (CSHA) which is a tool to assess medical, social, and psychological condition of a potential recipient to determine if an individual meets the needs-based State Plan HCBS eligibility criteria. For the targeting criteria for Traumatic Brain Injury or Acquired Brain Injury, the SMA uses medical records to confirm the diagnosis.

The SMA uses a CHSA tool which asks the recipients multiple questions related to treatment needs, level of ability (independent, requires assistance, supervision or prompting) to perform the seven ADLS. The risk factors are determined from multiple questions asked during the evaluation from their living situation/housing, self-reported medical conditions and medical records to confirm chronic medical conditions and behaviors as well as other resource needs.

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

A recipient must need hands-on assistance or prompting in at least two Activities of Daily Living (bathing, dressing, grooming, toileting, transfer, mobility, eating) and must also have one of the following risk factors:

- At risk of social isolation due to lack of family or social supports; or
- At risk of a chronic medical condition being exacerbated if not supervised by a registered nurse; or
- At risk of aggressive behavior if not supervised by a registered nurse or if medication is not administered by an appropriate staff; or
- At risk of their medical condition worsening, a person with a brain injury requires supervision by a trained direct care staff.

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)
A recipient must need hands-on assistance or prompting in at least two Activities of Daily Living (bathing, dressing, grooming, toileting, transfer, mobility, eating) and must also have one of the following risk factors: • At risk of social isolation due	The individual's condition requires services for three of the following: 1. Medication, 2. Treatment/Special Needs, 3. ADLs, 4. Supervision, or 5. IADLs.	The individual has a diagnosis of intellectual disability or related condition and requires active treatment due to substantial deficits in three of the following: 1. Mobility, 2. Self-Care, 3. Understanding and Use of Language, 4. Learning,	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, 3. Risk of serious medical complications, or

to lack of family or social supports. • At risk of a chronic medical condition being exacerbated if not supervised by a registered nurse; or • At risk of aggressive behavior if not supervised by a registered nurse or if medication is not administered by an appropriate staff; or. • At risk of their medical condition worsening, a person with a brain injury requires supervision by a trained direct care staff.		5. Self-Direction, or 6. Capacity for Independent Living	4. Need for 24-hour supervision

*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 5 years. At least 90 days prior to the end of this 5-year period, the

state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

This benefit targets individuals 18 years and over. For Day and Residential Habilitation Services, individuals must have a Traumatic Brain Injury (TBI) or an Acquired Brain Injury (ABI).

☐ **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, and (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:

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.)

Individuals in this benefit will receive 1915(i) services in the following settings:

- Adult Day Health Care Center – A setting for elderly, physically disabled and intellectually and developmentally disabled recipients who are in need for supervision due to medical, behavioral and physical issues and require the presence of a RN to monitor behaviors and administer medication during the day.
- Day Habilitation – A setting that provides treatment to recipients with TBI or ABI outside their homes or residential facilities.
- Residential Habilitation – A setting for individuals with TBI or ABI, who require services 24 hours per day in a normalized living environment and are not ready to live independently due to their functional or cognitive impairments.

The SMA will assess and determine that all 1915(i) settings initially meet all of the HCBS requirements through the provider enrollment process where prior to enrollment, the state will conduct an initial review of providers to ensure settings requirements are met prior to providing 1915(i) services. Additionally, providers must review and sign the HCBS Final Regulation Declaration.

Through ongoing provider reviews and incorporated settings requirements, the state will ensure that settings continue to meet all of the HCBS settings requirements, the State conducts comprehensive site-specific assessments for providers based on the enrollment revalidation schedules. If a provider is found to be non-compliant with the HCBS settings rule, the State sends a letter of remediation to the provider, outlining the areas of non-compliance and requesting a corrective action plan to address the identified issues. If providers do not come into compliance within the required time frames, they will be terminated as Medicaid providers.

The State will utilize the consolidated (ongoing and HS questionnaire) HCBS Provider Tool for provider to review. Using the three HS prongs as a guide, if the state determines that a setting falls under one of the three prongs, a discussion with the provider will be held to determine if can/will overcome the presumptive institutional characteristics. Provider must provide the state evidence and process of how they will overcome the presumptive institutional characteristics. The state will prepare a HS packet, post it for public comment for 30 days, then submit to CMS for review. If CMS agrees then provider can resume the provision of HCBS services. If the provider is not able to overcome the presumptive institutional characteristics, then recipients will be assisted to transition to another provider who meets all settings requirements.

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):*

   SMA Health Care Coordinator or SMA designated representative are responsible for conducting the independent assessment. All SMA Health Care Coordinators and SMA designated representatives receive training on person-centered thinking.

   Qualifications:

   SMA Health Care Coordinator (HCC) or SMA designated representative must be licensed as a Social Worker by the State of Nevada Board of Examiners for Social Workers; licensure as a Registered Nurse by the Nevada State Board of Nursing; or have a professional license or certificate in a medical specialty applicable to the assignment. Additional Criteria includes valid driver's license to enable site and home visits, adhere to Health Insurance Portability and Accountability Act (HIPAA) requirements and FBI Criminal History Background Check (standard for all State employees).

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):*

   SMA Health Care Coordinator or SMA designated representatives are responsible for developing the person-centered service plan.

   Qualifications:

   SMA Health Care Coordinator (HCC) or SMA designated representative must be licensed as a Social Worker by the State of Nevada Board of Examiners for Social Workers; licensure as a Registered Nurse by the Nevada State Board of Nursing; or have a professional license or certificate in a medical specialty applicable to the assignment. Additional Criteria includes valid driver's license to enable site and home visits, adhere to Health Insurance Portability and Accountability Act (HIPAA) requirements and FBI Criminal History Background Check (standard for all State employees).

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 SMA HCC or SMA designated representative is responsible for the development of Plan of Care (POC) using a person-centered plan.

During the initial assessment, and development of the person-centered POC, the potential recipient, family, support systems, and/or designated representatives are encouraged to participate in the development of the POC and to direct the process to the maximum extent possible. The person-centered planning process is driven by the individual, designated representative, legal guardian or other supports chosen by the individual and includes necessary information and support to ensure that the individual directs the process to the maximum extent possible.

Planning includes convenience to the recipient, cultural considerations, use of plain language, strategies for solving any disagreements, identification of what is important to and for the individual, personal preferences, choice of caregivers, strategies to facilitate health and welfare and remediate identified risks, identified goals, outcomes, preferences related to relationships, community integration and opportunities to participate in integrated settings/seek employment or volunteer activities, control over personal resources.

A POC form must be developed for all potential recipients. The POC includes, at a minimum, the individual's needs, goals to meet those needs, identified risks and services to be provided.

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):*

During the development and review of the POC with the recipient or their Authorized Representative (AR), and at any time during the authorization period, the SMA HCC or designated representative informs and provides a list of qualified providers so the recipient may choose their provider(s) of service. The POC includes a section that the recipient or their AR signs to acknowledge the choice of services and providers.

The information reviewed with the recipient/personal representative include: process for development of the POC, services to be provided, and choice of service provider. The recipient may request a change in services or service provider at any time.

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):*

The POC is developed and implemented by the SMA HCC or designated representative using a person-centered process. The HCC or designated representative contacts all service providers to arrange for the agreed upon services.

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):*				

Services

- **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:	**Adult Day Health Care**
Service Definition (Scope):	
Adult Day Health Care (ADHC) services provide assistance with the activities of daily living, medical equipment and medication administration. Services are generally furnished in four or more hours per day on a regularly scheduled basis, for one or more days per week, in a non-institutional, community-based setting. The schedule may be modified as specified in the plan of care. Services include care coordination, nursing services, nutritional assessment, assistance in activities of daily living or instrumental activities of daily living, social activities and meals (*shall not constitute a "full nutritional regimen" (3 meals per day)*.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	
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):*
	No more than 6 hours per day per recipient. If a recipient needs more than 6 hours of this service, the recipient or their AR will work with the HCC to develop an individualized back-up plan.
☐	Medically needy *(specify limits):*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Another Standard *(Specify):*
Adult Day Health Care Center	Licensed by the Division of Public and Behavioral Health, Bureau of Health Care Quality and Compliance		Must maintain a Medicaid Services Provider Agreement and comply with the criteria set forth in the Medicaid Services Manual. All staff and volunteers must complete annually a one-hour training on the HCBS Final Rule including recipient rights.

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):*
Adult Day Health Care Center	Nevada Medicaid Provider Enrollment Unit Division of Public and Behavioral Health, Bureau of Health Care Quality and Compliance	Every five years. Every six years, unless compliant circumstances warrant provider review.

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: **Day Habilitation**

Service Definition (Scope)*:*

This service is targeted to individuals with a Traumatic Brain Injury (TBI) or Acquired Brain Injury (ABI). Day Habilitation services are regularly scheduled activities in a non-residential setting, separate from the recipient's private residence or other residential living arrangement. Services include assistance with the acquisition, retention, or improvement in self-help, socialization, and adaptive skills that enhance social development and develop skills in performing activities of daily living and community living.

Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independent and personal choice. Services are identified in the recipient's POC according to recipient's need and individual choices. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

Day Habilitation services focus on enabling the participant to attain or maintain his or her maximum potential and shall be coordinated with any needed therapies in the recipient's POC such as physical, occupational, or speech therapy.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

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):*

	Limited to 6 hours per day. If a recipient needs more than 6 hours of this service, the recipient or their AR will work with the HCC to develop an individualized back-up plan.
☐	Medically needy *(specify limits)*:

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

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Another Standard *(Specify)*:
Day Habilitation Provider	Licensed as a Facility for the Care of Adults During the Day by the Bureau of Health Care Quality and Compliance within the Division of Public and Behavioral Health	At least one full-time employee with Certified Brian Injury Specialist (CBIS) Certification through Brian Injury Association of America (BIAA)	Must maintain a Medicaid Services Provider Agreement and comply with the criteria set forth in the Medicaid Services Manual. All direct care staff must complete the Brain Injury Association of America (BIAA) Brain Injury Fundamentals Certification within six months of hire. In addition, all staff and volunteers must complete annually a one-hour training on the HCBS Final Rule including recipient rights.

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)*:
Day Habilitation Provider	Nevada Medicaid Provider Enrollment Unit Bureau of Health Care Quality and Compliance within the Division of Public and Behavioral Health	Every five years

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:	**Residential Habilitation**

Service Definition (Scope):

This service is targeted to individuals with a Traumatic Brain Injury (TBI) or Acquired Brain Injury (ABI). Residential Habilitation means individually tailored supports that assist with the acquisition,

retention, or improvement in skills related to living in the community. These services include adaptive skill development, assistance with activities of daily living, community inclusion, adult educational supports, social and leisure skill development, that assist the recipient to reside in the most integrated setting appropriate to his/her needs. Residential Habilitation also includes personal care and protective oversight and supervision.

Payment for Room and Board is prohibited, including the cost of building maintenance, upkeep, and improvement. The method by which the costs of room and board are excluded from payment for residential habilitation is specified in the 4.19-b pages.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

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):*

☐ Medically needy *(specify limits):*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Another Standard *(Specify):*
Residential Habilitation Provider	Licensed as a Residential Facility for Groups by the Bureau of Health Care Quality and Compliance within the Division of Public and Behavioral Health	At least one full-time employee with (CBIS) Certification through (BIAA)	Must maintain a Medicaid Services Provider Agreement and comply with the criteria set forth in the Medicaid Services Manual. All direct care staff must complete the Brain Injury Association of America (BIAA) Brain Injury Fundamentals Certification within six months of hire. In addition, all staff and volunteers must complete annually a one-hour training on the HCBS Final Rule including recipient rights.

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)*:
Residential Habilitation Provider	Nevada Medicaid Provider Enrollment Unit Bureau of Health Care Quality and Compliance within the Division of Public and Behavioral Health,	Every five years

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

- ☐ **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).

1. **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):*

2. **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):**

3. **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):*

4. **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
	☐	☐
	☐	☐

5. **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.

6. ☐ **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)*	Percent of person-centered service plans reviewed that participant's attest to adequately addressing their assessed needs. N = Number of plans reviewed that, via signature from the participant or their designated representative, attest that their needs are being addressed. D = Total number of person-centered service plans reviewed.
	Discovery Activity *(Source of Data & sample size)*	Record reviews, are conducted using a remote desk review. 10% review of all participants that have participated at any time during the review period.

Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency (SMA) Quality Assurance (QA) Unit and Long Term Services and Support (LTSS) 1915(i) Units.
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA LTSS 1915(i) Unit will remediate any issue or non-compliance within 90 days of the issuance of the final monthly report. Deficiencies are remediated through the monthly Quality Improvement (QI) meeting. The QI team consists of SMA QA and LTSS 1915(i) Units.
Frequency *(of Analysis and Aggregation)*	Monthly, Quarterly, and Annually

Requirement	***1.b) Service plans are updated annually***
Discovery	
Discovery Evidence *(Performance Measure)*	Percent of person-centered service plans that are updated at least once annually. N = Number of person-centered service plans that are updated at least once annually, in the same month or earlier. D = Total number of person-centered service plans reviewed.
Discovery Activity *(Source of Data & sample size)*	Record reviews, are conducted using a remote desk review. 10% review of all participants that have participated at any time during the review period.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA QA and LTSS 1915(i) Units

Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA LTSS 1915(i) Unit will remediate any issue or non-compliance within 90 days of the issuance of the final monthly report. Deficiencies are remediated through the monthly QI meeting. The QI team consists of SMA QA and LTSS 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)*	Percent of person-centered service plans reviewed that indicate 1915(i) participants were given a choice when selecting services and providers. N = Number of person-centered service plans reviewed that document 1915(i) participants were given a choice when selecting services and providers. D = Total number of person-centered service plans reviewed
Discovery Activity *(Source of Data & sample size)*	Record reviews, are conducted using a remote desk review. 10% review of all participants that have participated at any time during the review period.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA QA and LTSS 1915(i) Units
Frequency	Monthly, Quarterly and Annually
Remediation	

	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA LTSS 1915(i) Unit will remediate any issue or non-compliance within 90 days of the issuance of the final monthly report Deficiencies are remediated through the monthly QI meeting. The QI team consists of SMA QA and LTSS 1915(i) Units.
	Frequency *(of Analysis and Aggregation)*	Monthly, Quarterly, and Annually

Discovery Evidence *(Performance Measure)*	
Discovery Activity *(Source of Data & sample size)*	
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	
Frequency	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	
Frequency	

(of Analysis and Aggregation)	

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)*	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, are conducted using a remote desk review. 100% review of all new applicants that had an evaluation during the state plan year.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA LTSS 1915(i) Unit
	Frequency	Monthly, Quarterly and Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA LTSS 1915(i) Unit will remediate any issue or non-compliance within 90 days. Deficiencies are remediated through the Quarterly Unit meeting. The team consists of SMA LTSS 1915(i) Units.
	Frequency *(of Analysis and Aggregation)*	Monthly, Quarterly, and Annually

Discovery

Discovery Evidence *(Performance Measure)*	
Discovery Activity *(Source of Data & sample size)*	
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	
Frequency	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	
Frequency *(of Analysis and Aggregation)*	

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)*	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 *(Source of Data & sample size)*	Record reviews, are conducted using a remote desk review. 10% review of all participants that have participated at any time during the review period.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA QA and LTSS 1915(i) Units
Frequency	Monthly, Quarterly, and Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA QA and LTSS 1915(i) Units are 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 LTSS 1915(i) unit will remediate any issue or non-compliance within 90 days of the issuance of the final monthly report. Deficiencies are remediated through the monthly QI meeting. The QI team consists of SMA QA and LTSS 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)*	Percentage of enrolled recipients whose 1915(i) benefit Needs Based eligibility Criteria, was reevaluated at least annually. N: Number of enrolled recipients whose Needs Based Criteria was reevaluated at least annually, within the same month or earlier. D: Number of enrolled recipients reviewed.
Discovery Activity *(Source of Data & sample size)*	Record reviews, are conducted using a remote desk review. 10% review of all participants that have participated at any time during the review period.

Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA QA and LTSS 1915(i) Units
Frequency	Quarterly, Annually, and Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA LTSS 1915(i) unit will remediate any issue or non-compliance within 90 days of the issuance of the final monthly report. Deficiencies are remediated through the monthly QI meeting. The QI team consists of SMA QA and LTSS 1915(i) Units.
Frequency *(of Analysis and Aggregation)*	Quarterly, Annually, and Ongoing

Requirement	**3. Providers meet required qualifications.**
Discovery	
Discovery Evidence *(Performance Measure)*	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	SMA LTSS 1915(i) Unit, Provider Enrollment Unit and SMA Fiscal Agent.

	Responsibilities *(Agency or entity that conducts discovery activities)*	
	Frequency	Initially or on re-validation schedule
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA LTSS 1915(i), and Provider Enrollment Units and Fiscal Agent. State Medicaid Agency will remediate any issue or non-compliance within 90 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)*	Initially and on revalidation.

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)*	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 and on-site. 100% Review.
Monitoring Responsibilities *(Agency or entity that conducts*	SMA LTSS 1915(i) Unit and Provider Enrollment Unit

	discovery activities)	
	Frequency	Initially and on re-validation
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	State Medicaid Agency will remediate any issue or non-compliance within 90 days. Deficiencies are remediated by the LTSS 1915(i) Unit, Provider Enrollment and the Providers.
	Frequency *(of Analysis and Aggregation)*	Initially or on re-validation schedule

Requirement	**5. The SMA retains authority and responsibility for program operations and oversight.**
Discovery	
Discovery Evidence *(Performance Measure)*	Percent of issues reported and identified to SMA that were addressed as required by the state. N = Number of issues reported and identified to SMA that were addressed as required by the State. D = Total number of issues identified.
Discovery Activity *(Source of Data & sample size)*	100% Review of reported and identified issues relate SMA outside of provider qualifications and settings.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA LTSS 1915(i) Unit.
Frequency	Monthly, Quarterly, Annually
Remediation	

Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA Surveillance and Utilization Review (SUR) Unit will remediate any issue or non-compliance within 12 months of notification. Deficiencies are remediated through the state SUR Unit using recoupments or letters of instruction.
Frequency *(of Analysis and Aggregation)*	Annually

Discovery	
Discovery Evidence *(Performance Measure)*	Number of providers reviewed by Health Care Quality and Compliance (HCQC) that received a Statement of Deficiency (SOD) and implemented a Plan of Correction (POC). N: Number of the providers that received a Statement of Deficiency (SOD) and implemented a Plan of Correction (POC) reviewed by SMA. D: Total Number of providers reviewed by HCQC that received a Statement of Deficiency (SOD) and implemented a Plan of Correction (POC).
Discovery Activity *(Source of Data & sample size)*	Records review 100% Review.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA LTSS 1915(i) Unit
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 90 days.

	timeframes for remediation)	
	Frequency *(of Analysis and Aggregation)*	Annually, Continuously and Ongoing

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)*	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; Minimum 10% Review.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA QA Unit
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA SUR Unit will remediate any issue or non-compliance within 12 months of notification. Deficiencies are remediated through the state SUR Unit using recoupments or letters of education and instruction.
Frequency *(of Analysis and Aggregation)*	Annually

Discovery	
Discovery Evidence *(Performance Measure)*	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 services were rendered as signed by recipient or AR. D: Total number of claims reviewed.
Discovery Activity *(Source of Data & sample size)*	Financial records; Minimum 10% Review.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA QA unit
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA SUR Unit will remediate any issue or non-compliance within 12 months of notification. Deficiencies are remediated through the state SUR Unit using recoupments or letters of instruction.
Frequency *(of Analysis and Aggregation)*	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, 100% Review.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA LTSS 1915(i) Unit
Frequency	Annually, Continuously and Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA LTSS 1915(i) Unit 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 LTSS 1915(i) supervisor review monthly and for SMA QA review annually.
Frequency *(of Analysis and Aggregation)*	Monthly, Quarterly, and Annually

Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of incident reviews/investigations that were followed-up and completed regarding unexplained deaths, abuse, neglect, exploitation and unapproved restraints as required by the SMA. N: Number of incident reviews/investigations that were followed-up and completed regarding unexplained deaths, abuse, neglect, exploitation and unapproved restraints as required by the SMA. D: Total Number of incidents received regarding unexplained deaths, abuse, neglect, exploitation and unapproved restraints.
Discovery Activity *(Source of Data & sample size)*	Records review on-site, 100% Review.
Monitoring Responsibilities	SMA LTSS 1915(i) Unit

	(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. All Serious Occurrence Reports (SOR) must be reported within 24 hours of discovery. All SORs are entered into the incident management database, including follow-ups by HCC or designated representative. 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, HCC or designated representative will conduct all necessary follow-ups to include plan of correction, report submitted to law enforcement, Adult Protective Services (APS) or Health Care Quality and Compliance (HCQC) if applicable. The incident management database monitors and tracks all incidents and generates reports upon request. The LTSS 1915(i) Supervisor will review SORs on a weekly or as needed basis.
	Frequency *(of Analysis and Aggregation)*	Monthly, Quarterly, and 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 LTSS 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 LTSS 1915(i) Unit regarding how to perform case file 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 case management database for case file reviews. Provider records are managed through the Medicaid Management Information System(MMIS) and reviewed by the SMA Fiscal Agent and Provider Enrollment Unit. Electronic submission of claims is also done through MMIS, which has a built-in edits to ensure claims are processed correctly and appropriately.

Serious Occurrence Reports (SORs) are tracked through a incident management database which is monitored and reviewed by the LTSS 1915(i) Supervisor.

2. Roles and Responsibilities

The SMA QA Unit and LTSS 1915(i) Unit complete reviews of the performance measures outlined above.

LTSS 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 reviews. 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
	Reimbursement Methodology for Adult Day Health Care (ADHC) Services provided by a non-governmental entity and governmental entities who do not undergo the Medicaid cost identification and reporting procedures: Prior to the beginning of each rate year, each of the governmental providers providing ADHC services must select one of the reimbursement methodologies described below for reimbursement. For example, by April 30, 2013, governmental providers must select a methodology for the rate year beginning July 1, 2013. Once a selected methodology is determined for a rate year, governmental providers will not be able to change the selected methodology until the following rate year. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of ADHC services. The Agency's rates were set as of October 1, 2017 and are effective for services on or after that date. All rates are published on the Agency's website at http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/. The billable unit of service for ADHC is one unit per 15 minutes or the daily rate. • If services are authorized and provided for less than six hours per day, provider should bill one unit for each 15 minutes; • If services are authorized and provided for six hours or more per day, provider should bill the per diem rate.

Rate Methodology:

The rate is 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 rate:

- Wage information is taken 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 ADHC services.
- Employee related expenses (ERE) percentage of 27% was based on input from the Task Force members and Medicaid Staff. It includes paid vacation, paid sick leave, holiday pay, health insurance, life insurance, disability, workers compensation, and legally required payroll taxes.
- Productivity adjustment factor 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.
- Administrative overhead, 10%, is the percentage of service cost that should result from non-direct care activities. It includes insurance, administrative staff, operations and management activities and office supplies. Capital and related expenses is not included. It also does not include staff training.
- Allowances for capital costs – the costs are not included in the Administrative overhead. It includes the average hourly expense for building rental and maintenance, equipment leasing and utility expenses.

The following steps are used to determine the rate:

1. The State will use Nevada-specific hourly wages from the Bureau of Labor Statistics as of May 2004 inflated to June 2006.
2. This hourly compensation is increased by the 27% ERE.
3. A productivity factor is applied to the hourly compensation calculated in Item 2 to equal to the adjusted hourly rate.
4. Administrative overhead (10%) is applied to the adjusted hourly rate (Item 3).
5. Determine allowance for capital costs per hour.
6. Fixed hourly rate is the sum of adjusted hourly rate (Item 3), administrative overhead (Item 4) and capital costs (Item 5).
7. Fixed hourly rate is scaled to the proper unit based on the procedure code.

This rate has been compared to government entities who do not follow all cost reporting rules and other private sector fee-for-service rates. Documentation of the assumptions used, rate development methodology, and fee schedule payment rates will be maintained by the Division of Health Care Financing and Policy (DHCFP).

A. Reimbursement Methodology for Adult Day Health Care (ADHC) services provided by a state or local government entity:

ADHC services provided by a state or local government entity are reimbursed according to the following payment methodology. This methodology is used by providers who undergo all Medicaid cost identification, reporting, reconciliation and settlement procedures in accordance with 2 CFR 200.

I. 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 Adult Day Health Care 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 prescribed by Nevada Medicaid 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.

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

The annual Medicaid Cost Report includes a certification of expenditures 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 the DHCFP or its designee.

B. Settings 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 cognizant agency 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 cost details are accumulated on the annual cost report.

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

e) A CMS approved time study is required when providers of service do not spend 100% of their time providing the ADHC services described in the applicable section 3.1-A State Plan pages and is used to determine the percentage of time that service personnel spend on direct ADHC.

f) Services, general and administrative time, and all other activities to account for 100 Services, general and administrative time and all other activities to account for 100 per percent 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 Adult Day Health Care Services time study percentage is applied against the net direct and indirect costs

g) 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.

h) Total Medicaid allowable costs (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.

C. Facilities that are used for multiple purposes and the provision of medical services is 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.

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 cognizant agency 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 allowable amount. For these facilities, allowable costs are only those costs 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 Adult Day Health Care Services described in the applicable section 3.1-A State Plan pages and is used to determine the percentage of time that service personnel spend on direct Adult Day Health Care Services, general and administrative time, and all other activities to account for 100 percent 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 Adult Day Health Care 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 allocable and allowable costs.

1. Cost Reconciliation Process

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

2. 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:

1. Off-set all future claims payments from the provider until the amount of the federal share of the overpayment is recovered;
2. 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.

Services provided by an out-of-state provider require prior authorization by Nevada Medicaid, which must verify that the services required by Medicaid-eligible or pending-eligible clients are not available in Nevada. The out-of-state payment rate for services provided by an out-of-state provider is based on one of the following criteria:

a. The out-of-state provider will be paid the lesser of the provider's billed charges or the fee-for-service rate that is paid to an in-state provider for the service.

b. If the out-of-state provider refuses to accept this rate, then the out-of-state provider may be paid the lesser of the provider's billed charges or the same fee-for-service rate as it would be paid by its home state Medicaid program.

c. For services that cannot be provided by a provider that accepts payment under (A) or (B), the State will maintain a list of other qualified out-of-state providers and will negotiate competitive rates that will not exceed the provider's customary charge.

	Fixed hourly rate is scaled to the proper unit based on the procedure code. This rate has been compared to other private sector Fee-for-Service rates. Documentation of the assumptions used, rate development methodology, and fee schedule payment rates will be maintained by The Division of Health Care Financing and Policy. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of ADHC services. The agency's rates were set as of October 1, 2017 and are effective for services on or after that date. All rates are published on the agency's website at: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/
☒	HCBS Habilitation
	Rates paid to the providers for: Day Habilitation, and Residential Habilitation services were set in 2002 by the Nevada Provider Rates Task Force. EP&P consultant was contracted by the DHCFP to conduct an analysis of provider rates and make recommendations on rate-setting. The base rate for these services were developed and adopted by the DHCFP using a provider cost survey and market analysis. The rates are comprised of 1. The level of staffing (FTEs) per billing unit; 2. The wage level for supervisor and direct care staff using wage information from the Bureau of Labor Statistics; 3. Employee related expenses at 27% which includes benefits such as paid vacation, paid sick leave, holiday pay, health insurance, etc.; amount of non-billable time spent by staff (productivity adjustment at 30 minutes per day) as well as staff training time; 4. 15% was added to the hourly direct care and ERE cost for non-direct care activities. This is the base rate for these services. Public testimony is allowed during the Legislative process when rate increases are proposed through the budget process. The base rate is the same for all providers.

☐	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)