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State/Territory Name: **Nevada**

State Plan Amendment (SPA) #: **NV-25-0001**

This file contains the following documents in the order listed:

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2) Companion Letter
3) Form CMS-179
4) Approved SPA Page(s)

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

June 30, 2025

Stacie Weeks, Director
Nevada Department of Human Services
Division of Health Care Financing and Policy
1100 E. Williams Street, Suite 101
Carson City, NV 89701

RE: Nevada 25-0001 Specialized Foster Care §1915(i) home and community-based services (HCBS) state plan benefit renewal

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 NV 25-0001. The purpose of this amendment is to renew Nevada's 1915(i) State Plan HCBS benefit. The effective date for this renewal is July 1, 2025. Enclosed is a copy of the approved SPA.

Since the state has elected to target the population who can receive §1915(i) State Plan HCBS, CMS approves this SPA for a five-year period expiring 6/30/2030, 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 meets 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 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,

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

Enclosure

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

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

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June 30, 2025

Stacie Weeks, Director
Nevada Department of Human Services
Division of Health Care Financing and Policy
1100 E. Williams Street, Suite 101
Carson City, NV 89701

Dear Stacie Weeks:

This letter is being sent as a companion letter to Centers for Medicare & Medicaid Services (CMS) approval of State Plan Amendment (SPA) 25-0001, which was submitted to CMS on January 7, 2025, and renews the 1915(i) Specialized Foster Care benefit.

Under section 1902(a)(10)(A) of the Social Security Act (the Act), a state plan must provide for making medical assistance available to eligible individuals. "Medical assistance" is defined in section 1905(a) of the Act to mean payment of part or all costs of certain listed types of care and services in section 1905(a) of the Act, including care and services provided pursuant to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements in section 1905(a)(4)(B) and (r) of the Act. The EPSDT requirements entitle eligible children under the age of 21 to Medicaid coverage of health care, diagnostic services, treatment, and other measures described in section 1905(a) that are medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions, whether such services are covered under the state plan.

Nevada's 1915(i) Specialized Foster Care benefit includes coverage of crisis stabilization services; however, these services are coverable under section 1905(a) and therefore must be covered for EPSDT-eligible children under age 21 under the 1905(a)-state plan. Therefore, we request that Nevada remove this service from the state's section 1915(i) Specialized Foster Care benefit and cover it under the section 1905(a) state plan.

The state has 90 days from the date of this letter to address the issue described above. During this period, the state must either submit a SPA removing crisis stabilization services from the 1915(i) Specialized Foster Care benefit or submit a corrective action plan that describes in detail how the state will resolve the issues in a timely manner. Failure to respond may result in the initiation of a formal compliance process. During the 90-day compliance period, CMS will be available to provide technical assistance if needed.

If you have any questions concerning this information, please contact me at (410) 786-7561. You may also contact Kathleen Creggett at (415) 744-3656 or Kathleen.Creggett@cms.hhs.gov.

Sincerely,

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

Enclosure

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

DEPARTMENT OF HEALTH ANDHUMAN 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: 25-0001

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
July 1, 2025

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 441 Subpart M

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 2.2-A pages 28-29~~
Attachment 3.1-I.2 Pages 1 - ~~40~~ 44
Attachment 4.19-B Pages 18 - 18f

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
~~Attachment 2.2-A Pages 28 - 29~~
Attachment 3.1-I.2 Pages 1 - 47
Attachment 4.19-B Pages 18 - 18f

9. SUBJECT OF AMENDMENT
1915(i) - HCBS State Plan Option for Intensive In-Home Services and Crisis Stabilization-Application Renewal

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:

CY OFFICIAL

12. TYPED NAME
RICHARD WHITLEY

13. TITLE
DIRECTOR, DHHS

14. DATE SUBMITTED
December 31, 2024

15. RETURN TO
Cynthia Leech, Compliance Agency Manager
DHCFP/Medicaid
4070 Silver Sage Drive
Carson City, NV 89701

FOR CMS USE ONLY

16. DATE RECEIVED 1/7/2025

17. DATE APPROVED June 30, 2025

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL 7/1/2025

19. SIGNATURE OF APPROVIN

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

21. TITLE OF APPROVING OFFICIAL
Division Director

22. REMARKS

CMS requested and received approval to edit box 7 to remove Attachment 2.2-A pages 28-29 from this document.

CMS requested and received approval to edit box 7 to change the pages from 1-40 to 1-44.

Instructions on Back

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

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

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

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

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

***Select one*:**

☑	**Not applicable**
○	**Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act.** The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. *Specify:*
(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);
(b) the geographic areas served by these plans;
(c) the specific 1915(i) State plan HCBS furnished by these plans;
(d) how payments are made to the health plans; and
(e) whether the 1915(a) contract has been submitted or previously approved.

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates (*check each that applies*):

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

	☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of providers)
☐	**A program operated under §1932(a) of the Act.** *Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:*			
☐	**A program authorized under §1115 of the Act.** *Specify the program*:			

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

○	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:	
○	The Medical Assistance Unit *(name of unit)*:	
○	Another division/unit within the SMA that is separate from the Medical Assistance Unit	
	(name of division/unit) This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.	
☑	The State plan HCBS benefit is operated by *(name of agency)*	
	Division of Child and Family Services (DCFS)	
	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	☑	☑	☐	☐
10Quality assurance and quality improvement activities	☑	☑	☑	☑

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

Acronym	Name	Entity	Entity Type
DHCFP	Division of Health Care Financing Policy	State	State Medicaid Agency (SMA)
DCFS	Division of Child and Family Services	State	State Operating Agency
FAC	Fiscal Agent Contractor	Private	Contracted Entity
CCFS	Clark County Family Services	County	Local Non-State Entity
WCHSA	Washoe County Human Services Agency	County	Local Non-State Entity
CCJJS	Clark County Juvenile Justice Services	County	Local Non-State Entity

Function 1: DHCFP/ SMA will provide oversight of DCFS and the Local Non-State Entities as they perform the Individual State Plan HCBS Enrollment.
Function 2: DHCFP/ SMA will provide oversight of DCFS and the Local Non-State Entities performing Initial and re-evaluation of eligibility.

Function 3: DHCFP/ SMA will provide oversight of DCFS and Local Non-State Entities who review Participant's Service Plans.

Function 4: DHCFP/SMA or their FAC will be responsible for Prior Authorization (PA) activities.

Function 5: DHCFP/SMA or their FAC will perform Utilization Management

Function 6: DHCFP/SMA, FAC, Operating Agency and Local Non-State Entities are responsible for qualified Medicaid provider enrollment.

Function 7: DHCFP/ SMA and FAC are responsible for execution of Medicaid Provider Agreement

Function 8: DHCFP/ SMA is responsible for establishment of consistent rate methodology for each State Plan HCBS.

Function 9: DHCFP/ SMA and DCFS are responsible for developing rules, policies, procedures, and information governing each State Plan HCBS benefit.

Function 10: DHCFP/SMA, DCFS, FAC, and Local Non-State Entities perform quality assurance and quality improvement activities.

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

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

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

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

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

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

Number Served

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

Annual Period	From	To	Projected Number of Participants
Year 1	7/1/2025	6/30/2026	640
Year 2			
Year 3			
Year 4			
Year 5			

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

Financial Eligibility

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

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

☑ The State does not provide State plan HCBS to the medically needy.

☐ The State provides State plan HCBS to the medically needy. (*Select one*):

☐ The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services.

☐ The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

Evaluation/Reevaluation of Eligibility

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

○	Directly by the Medicaid agency
☑	By Other (*specify State agency or entity under contract with the State Medicaid agency*):
	Division of Child and Family Services (DCFS), Clark County Family Services (CCFS), Washoe County Human Services Agency (WCHSA), Clark County Juvenile Justice Services (CCJJS).

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

The Care Coordinator is the individual responsible for performing evaluation/reevaluation of eligibility who must be independent and have one of the following qualifications:

Qualified Mental Health Associate (QMHA)

A person who meets the following documented minimum qualifications:

a. Licensure as a Registered Nurse (RN) in the State of Nevada or holds a bachelor's degree from an accredited college or university in a human, social services or behavioral field with additional understanding of Rehabilitative Mental Health (RMH) treatment services and case file documentation requirements; or

b. Holds an associate degree from an accredited college or university in a human, social services or behavioral field with additional understanding of RMH treatment services, and case file documentation and has four years of relevant professional experience of providing direct services to participants with mental health disorders; or

c. An equivalent combination of education and experience as listed in 1-2 above; and

d. Whose education and experience demonstrate the competency under clinical supervision to:

i. Direct and provide professional therapeutic interventions within the scope of their practice and limits of their expertise.
ii. Identify presenting problem(s);
iii. Participate in treatment plan development and implementation.
iv. Coordinate treatment.
v. Provide parenting skills training.
vi. Facilitate discharge plans; and
vii. Effectively provide verbal and written communication on behalf of the recipient to all involved parties.

e. Has a Federal Bureau of Investigation (FBI) background check in accordance with the Qualified Behavioral Aides (QBA) provider qualifications listed under Section 403.6A of the Nevada MSM.

Qualified Mental Health Professional (QMHP)

A Physician, Physician's Assistant or a person who meets the definition of a QMHA and meets the following documented minimum qualifications:

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

2. Who is employed and determined by a state mental health agency to meet established class specification qualifications of a Mental Health Counselor; and

3. Whose education and experience demonstrate the competency to identify precipitating events, conduct a comprehensive mental health assessment, diagnose a mental or emotional disorder and document a current ICD diagnosis, determine intensity of service's needs, establish measurable goals, objectives and discharge criteria, write and supervise a treatment plan and provide direct therapeutic treatment within the scope and limits of their expertise.

Qualified Mental Health Professionals (QMHP) Interns/ Assistants:

a. Clinical Social Worker Interns meet the requirements under a program of internship and are licensed as an intern pursuant to the State of Nevada, Board of Examiners for Social Workers (Nevada Administrative Code (NAC) 641B).

b. Marriage and Family Therapist and Clinical Professional Counselor Interns who meet the requirements under a program of internship and are licensed as an intern pursuant to the State of Nevada Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors.

c. Psychological Assistants who hold a doctorate degree in psychology, is registered with the State of Nevada Board of Psychological Examiners (NAC 641.151) and is an applicant for licensure as a Licensed Clinical Psychologist who has not yet completed the required supervised postdoctoral experience approved by the Board.

d. Psychological Interns registered through the Psychological Board of Examiners defined in NAC 641.165. Interns must be supervised in accordance with state regulations and may only provide services within the scope of their licensure.

e. Psychological Trainees registered through the Nevada Board of Psychological Examiners and has a designated licensed Psychologist through the Board of Psychological Examiners may render and their supervisor may bill for their services pursuant to NRS and NAC 641.

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:

Care Coordinators utilize a comprehensive biopsychosocial assessment and the level of care decision support tools, the Early Childhood Service Intensity Instrument (ESCII) for recipients ages 0-5, the Child and Adolescent Services Intensity Instrument (CASII) for recipients ages 6-17, or the Level of Care Utilization System (LOCUS) for recipients ages 18-19to evaluate an individual's eligibility for this 1915(i) benefit. The Care Coordinator also reviews clinical indicators of impaired functioning: Prior psychological assessment record, prior placement history, and prior treatment history.

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

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

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

Participants must meet the following minimum needs-based criteria to be eligible for this 1915(i) benefit:

Impaired Functioning & Service Intensity: Participants must demonstrate a need for clinical supervision with medication management and/or assistance with managing and coordinating behavioral health supports and services as evidenced by a minimum CASII, ECSII, or LOCUS level of 1 score.

AND

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

1. Current placement in an emergency shelter or non-institutional congregate care due to behavioral and mental health needs;
2. Transitioned to a community-based living arrangement with intensive behavioral supports when returning or stepping down from residential treatment center or other higher level of care placement; and/or
3. At risk of higher level of care placement because prior traditional family foster care and/or less restrictive community treatment services have not been successful.

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

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)
Recipients must need minimum requirements to be considered for 1915(i) services: 1. Impaired Functioning & Service Intensity: Participants must demonstrate a need for clinical supervision with medication management and/or assistance with managing and coordinating behavioral health supports and services as evidenced by a minimum CASII, ECSII, or LOCUS level of 1 score.	The individual's condition requires services for three of the following: 1. Medication 2. Treatment/Special Needs, 3. ADLs, 4. Supervision, or 5. IADLs.	In order to meet the ICF-IID level of care criteria, the recipient must meet all of the following: 1. Have substantial functional impairments in three (3) or more of six (6) areas of major life activity (mobility, selfcare, understanding and use of language, learning, self-direction, and capacity for independent living). For recipients age six years and younger, to have intensive support needs in areas of behavioral skills, general skills training, personal care, medical intervention, etc., beyond those required for recipients of the same age. 2. The recipient has a diagnosis of an intellectual disability, or a related	The recipient 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 4. Need for 24-hour supervision.

AND 2. **Other Community Alternatives:** The accessibility and/or intensity of currently available community supports and services are inadequate to meet these needs due to the severity of the impairment without the provision of one or more of the services contained in the HCBS Benefit, as determined by the DCFS or its designee, as evidenced by at least one of the following risk factors: • At risk of higher level of care placement due to recent placement disruption within the past six months; • Current placement in emergency		condition. The onset of an intellectual disability must have occurred before the age of 18, and the onset of a related condition must have occurred on or before age 22. 3. Must require monthly supports by, or under the supervision of, a health care professional or trained support personnel. 4. The monthly support may be from one entity or may be a combination of supports provided from various sources. 5. The recipient cannot be maintained in a less restrictive environment without supports or services. Through the assessment process the team has identified the individual as being at risk of n institutional placement (ICF/IID) without the provision of at least monthly supports.	

shelter or non-institutional congregate care due to behavioral and mental health needs; Transitioned to a community-based living arrangement with intensive behavioral supports when returning or stepping down from residential treatment center or other higher level of care placement; and/or At risk of higher level of care placement because prior traditional family foster care and/or less restrictive community treatment services have not been successful.			

*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)*):

Target Group. Recipient must meet all of the following:

1. Recipient must be under 19 years of age at the time of enrollment; they may continue in HCBS benefit through age 19

AND

2. Recipient must have a Diagnostic and Statistical Manual of Mental Disorders (DSM-5) or Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-3) diagnosis.

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

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

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

9. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, 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.)

State plan HCBS benefits will be furnished to recipients aged 0-19 who reside and receive HCBS in a home in the community, not in an institution. This may include residence in a home or apartment that is a licensed specialized foster care home. These settings are the private homes of foster parents or group homes who must meet a number of standard environmental and physical space dimensions of the home which are geared toward the recipient needs who live there.

The 1915(i) Operating Agency and County Entities will verify the settings through a site visit to ensure these homes are compliant with Federal HCB settings requirements at 42 CFR 441.710(a)(1)-(2) prior to enrollment. The SMA will verify the site visit and adherence to the settings rule as part of the enrollment checklist. Further verification of post review is outlined within the plan of quality assurance. Nevada Administrative Code (NAC) 424 requires for an annual inspection of licensed foster homes and adherence to settings rule will be monitored.

Settings which fail to meet the settings criteria will not be able to bill until in compliance; those failing to get into compliance within 30 days will be disenrolled. NAC 424 outlines that each foster home shall plan activities that provide for and stimulate social relationship, creative activities, and hobbies. Recipients receiving 1915(i) services must be afforded an opportunity to participate in neighborhood, school, and other community groups appropriate to the age and needs of each recipient to the same standard as individuals not receiving HCBS services. Adherence to NAC 424 as outlined before is determined at time of enrollment, and annual inspections.

The recipient receiving 1915(i) HCBS Services will:
- Live in homes which are part of the community and close to provider services.
- Have a room(s) which meet the needs of the recipient from a physical and behavioral health perspective.
- Be free to move around in the home and is not restrained in any way.
- Be allowed to make life choices appropriate for the age of the recipient.
- If capable, assist in the selection of services and supports.
- Be in settings that can include additional individuals receiving care and members of the family.
- Have some services provided directly in the home. Other services will occur in provider locations.

Person-Centered Planning & Service Delivery

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

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

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

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

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

The Care Coordinator is the individual responsible for compiling all information needed from the clinician and CFT team in order to complete the assessment of need for 1915i services. Care Coordinators must, at minimum, meet the following qualifications:

Qualified Mental Health Associate (QMHA)

A person who meets the following documented minimum qualifications:

1. Licensure as a Registered Nurse (RN) in the State of Nevada or holds a bachelor's degree from an accredited college or university in a human, social services or behavioral field with additional understanding of Rehabilitative Mental Health (RMH) treatment services and case file documentation requirements; or

2. Holds an associate degree from an accredited college or university in a human, social services or behavioral field with additional understanding of RMH treatment services, and case file documentation and has four years of relevant professional experience of providing direct services to participants with mental health disorders; or

3. An equivalent combination of education and experience as listed in 1-2 above; and

4. Whose education and experience demonstrate the competency under clinical supervision to:

   i. Direct and provide professional therapeutic interventions within the scope of their practice and limits of their expertise.
   ii. Identify presenting problem(s);
   iii. Participate in treatment plan development and implementation.

iv. Coordinate treatment.
v. Provide parenting skills training.
vi. Facilitate discharge plans; and

Effectively provide verbal and written communication on behalf of the recipient to all involved parties.

1. Has a Federal Bureau of Investigation (FBI) background check in accordance with the Qualified Behavioral Aides (QBA) provider qualifications listed under Section 403.6A of the Nevada MSM.

Qualified Mental Health Professional (QMHP):

A Physician, Physician's Assistant or a person who meets the definition of a QMHA and meets the following documented minimum qualifications:

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

2. Who is employed and determined by a state mental health agency to meet established class specification qualifications of a Mental Health Counselor; and

3. Whose education and experience demonstrate the competency to: identify precipitating events, conduct a comprehensive mental health assessment, diagnose a mental or emotional disorder and document a current ICD diagnosis, determine intensity of service's needs, establish measurable goals, objectives and discharge criteria, write and supervise a treatment plan and provide direct therapeutic treatment within the scope and limits of their expertise.

OR

Qualified Mental Health Professionals (QMHP) Interns/ Assistants:

1. Clinical Social Worker Interns meet the requirements under a program of internship and are licensed as an intern pursuant to the State of Nevada, Board of Examiners for Social Workers (Nevada Administrative Code (NAC) 641B).

2. Marriage and Family Therapist and Clinical Professional Counselor Interns who meet the requirements under a program of internship and are licensed as an intern pursuant to the State of Nevada Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors.

3. Psychological Assistants who hold a doctorate degree in psychology, are registered with the State of Nevada Board of Psychological Examiners (NAC 641.151) and are an applicant for licensure as a Licensed Clinical Psychologist who has not yet completed the required supervised postdoctoral experience approved by the Board.

4. Psychological Interns registered through the Psychological Board of Examiners defined in NAC 641.165. Interns must be supervised in accordance with state regulations and may only provide services within the scope of their licensure.

5. Psychological Trainees registered through the Nevada Board of Psychological Examiners and has a designated licensed Psychologist through the Board of Psychological Examiners may render and their supervisor may bill for their services pursuant to NRS and NAC 641.

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

The Care Coordinator is the individual responsible for compiling all information needed from the clinician and CFT team in order to develop the person-centered service plan. Care Coordinators must, at minimum, meet the following qualifications:

Qualified Mental Health Associate (QMHA)

A person who meets the following documented minimum qualifications:

1. Licensure as a Registered Nurse (RN) in the State of Nevada or holds a bachelor's degree from an accredited college or university in a human, social services or behavioral field with additional understanding of Rehabilitative Mental Health (RMH) treatment services and case file documentation requirements; or

2. Holds an associate degree from an accredited college or university in a human, social services or behavioral field with additional understanding of RMH treatment services, and case file documentation and has four years of relevant professional experience of providing direct services to participants with mental health disorders; or

3. An equivalent combination of education and experience as listed in 1-2 above; and

4. Whose education and experience demonstrate the competency under clinical supervision to:

    a. Direct and provide professional therapeutic interventions within the scope of their practice and limits of their expertise.

b. Identify presenting problem(s);
c. Participate in treatment plan development and implementation.
d. Coordinate treatment.
e. Provide parenting skills training.
f. Facilitate discharge plans; and
g. Effectively provide verbal and written communication on behalf of the recipient to all involved parties.

5. Has a Federal Bureau of Investigation (FBI) background check in accordance with the Qualified Behavioral Aides (QBA) provider qualifications listed under Section 403.6A of the Nevada MSM.

Qualified Mental Health Professional (QMHP):

A Physician, Physician's Assistant or a person who meets the definition of a QMHA and meets the following documented minimum qualifications:

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

2. Who is employed and determined by a state mental health agency to meet established class specification qualifications of a Mental Health Counselor; and

3. Whose education and experience demonstrate the competency to: identify precipitating events, conduct a comprehensive mental health assessment, diagnose a mental or emotional disorder and document a current ICD diagnosis, determine intensity of service's needs, establish measurable goals, objectives and discharge criteria, write and supervise a treatment plan and provide direct therapeutic treatment within the scope and limits of their expertise.

OR

Qualified Mental Health Professionals (QMHP) Interns/ Assistants:

1. Clinical Social Worker Interns meet the requirements under a program of internship and are licensed as an intern pursuant to the State of Nevada, Board of Examiners for Social Workers (Nevada Administrative Code (NAC) 641B).

2. Marriage and Family Therapist and Clinical Professional Counselor Interns who meet the requirements under a program of internship and are licensed as an

intern pursuant to the State of Nevada Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors.

3. Psychological Assistants who hold a doctorate degree in psychology, are registered with the State of Nevada Board of Psychological Examiners (NAC 641.151) and are an applicant for licensure as a Licensed Clinical Psychologist who has not yet completed the required supervised postdoctoral experience approved by the Board.

4. Psychological Interns registered through the Psychological Board of Examiners defined in NAC 641.165. Interns must be supervised in accordance with state regulations and may only provide services within the scope of their licensure.

5. Psychological Trainees registered through the Nevada Board of Psychological Examiners and has a designated licensed Psychologist through the Board of Psychological Examiners may render and their supervisor may bill for their services pursuant to NRS and NAC 641.

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 development of the Person-Centered Service Plan (PCSP) will focus on a strengths and needs-driven approach that provides intensive care management in a team setting using a Child and Family Team (CFT) approach. The CFT team may include the Care Coordinator, Case Worker, Provider Case Manager, recipient, caregiver(s), support persons identified by the family (paid and unpaid), Person Legally Responsible (PLR), Guardian Ad litem, and service providers, including the recipients' treating clinicians as available.

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

The CFT Team will utilize assessments to create the individualized participant service plan/PCSP for recipients and families. The plan will include needs, outcomes, and strategies that are:

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

The participant service plan/PCSP will include detailed service plans for applicable 1915(i) services. The CFT shall develop the initial participant service plan/PCSP, which will be approved by the Care Coordinator. The Care Coordinator will also be responsible for the approval of updates to the participant service plan/PCSP, including recommendations and decisions made by the CFT. The Care Coordinator is responsible for submitting the developed participant service plan/PCSP to the QIO-like vendor for approval.

The recipients' family is informed verbally and in writing about overall services available in the State Plan HCBS benefit at the time they make the choice to receive 1915(i) services. This means that parent(s) or legally responsible person, recipient and family members are the primary decision makers in the care of their family. The CFT Team is responsible for working with the recipient, family, and team to develop the participant service plan/ PCSP through the process outlined below.

At the first face-to-face meeting, between the case worker, recipient and family after enrollment, the Clinician/QMHP will:

a. Administer the appropriate assessment, as designated by DCFS

b. Execute signing of releases of information and all necessary consents
c. And facilitate the family sharing their story

The CFT team, which includes the recipient and informal/formal supports will determine the family vision. The planning process will determine the specific services and supports required in order to achieve the goals identified in the service plan/PCSP. The Team will review and update the service plan/PCSP at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the recipient and/or legal guardian.

The service plan/PCSP must also address the methods used to ensure the active participation of the recipient and/or the legally responsible person and others to develop such goals and to identify the steps or actions each CFT member will take to respond to the assessed service needs of the recipient. This will be demonstrated by all CFT members signing and dating the service plan/PCSP within the first 60 days of initial CFT meeting, at least annually, and upon any updates made to the service plan/PCSP as needed.

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):*

Services and providers are discussed during the CFT team meeting to develop the Participant Service Plan/ PCSP.

All recipients and/or legal guardians review and sign the Participant Service Plan/ PCSP at least annually or as needed. The signed plan indicates that the recipient and/ or their legal guardian acknowledge that they have been provided with a choice of services and providers.

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

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

DHCFP, through collaboration with DCFS, delegates the responsibility of the development and implementation of the Participant Service Plan/ PCSP to the Operating Agency and the Local Non-State Entities using the person-centered service planning process.

The Operating Agency and the Local Non-State Entities internally approve their Participant Service Plan/ PCSP. DHCFP reviews 10% of the approved plans to ensure the health, welfare and safety of the recipients and that all addressed needs are met.

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):*	DCFS and Local Non-State Entities			

Services

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

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	**Intensive In-Home Supports and Services**
Service Definition (Scope):	

Intensive In-Home Supports and Services include:

- Evidence-based interventions that target emotional, cognitive, and behavioral functioning within a variety of actual and/or simulated social settings, which include activities designed to foster the acquisition of skills, building positive social behavior and interpersonal competence. Services focus on enabling the recipient to attain or maintain his or her maximum potential and shall be coordinated with needed behavioral and physical health services and supports in the recipients' person-centered services and support plans.

- Regular support and technical assistance to the treatment parents in their implementation of Intensive In-Home Supports and Services. The fundamental components of technical assistance are the design or revision of in-home treatment strategies including proactive goal setting and planning, the provision of ongoing recipient-specific skills training and the problem-solving during home visits.

- Addressing day to day behavioral problems and the functions of these problems and related skill deficits and assets related to the recipients' behaviors and the interactions that motivate, maintain, or improve behavior.

Intensive In-Home Supports and Services may serve to reinforce skills, behaviors or lessons taught through other services.

Intensive In-Home Supports and Services may be furnished to children in foster care living arrangements but only to the extent that this service supplements maintenance and supervision services furnished in such living arrangements, and the service is necessary to meet the identified needs of the child. Pursuant to 42 CFR § Subpart D, 1915(i) funds are not available to pay for maintenance (including room and board) and supervision of children who are under the state's custody regardless of whether the child is eligible for funding under Title IV-E of the Act. The state assures that the claim for FFP for Intensive In-Home Supports and Services does not include costs that are properly charged as Title IV-E administrative expenses.

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

N/A

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

(Choose each that applies):

☑ Categorically needy *(specify limits):*

The amount, frequency and duration of this service is based on the recipients' assessed needs and documented in the approved participant service plan/PCSP. Eligible setting includes the recipients' home.

Service Limitations: Intensive In-Home Services and Supports Without Coaching – Provided in-home by the treatment foster parent(s). Maximum of two hours per day, seven days a week.

Service Limitations: Intensive In-Home Services and Supports with Coaching – Provided in-home by a trained coach supporting the treatment foster parent(s) to deliver evidence-based interventions to fidelity. Maximum of one hour per week.

☐ Medically needy *(specify limits):*

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

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

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Intensive Home-based provider	State Medicaid Agency - Division of Health Care Financing and Policy	Provider contract is effective for 60 months from enrollment date of its issuance and may be renewed upon expiration date.
Specialized Foster Care Agency	Operating Agency – Division of Child and Family Services	Pursuant to NAC 424, an application for a license to operate a foster care agency must be in a form prescribed by the Division and submitted to the appropriate licensing authority. Such a license is effective for two years after the date of its issuance and may be renewed upon expiration.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications (*Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: **Crisis Stabilization Services**

Service Definition (Scope)*:*

Crisis Stabilization services are short-term, outcome-oriented, and of higher intensity than other behavioral interventions that are designed to provide interventions focused on developing effective behavioral management strategies to secure recipient and family/caregiver's health and safety following a crisis. These services may only be delivered in an individual, one-to-one session and are available in the recipients' home. The service is short-term designed to achieve community stabilization through psychoeducation, crisis stabilization, and crisis resolution support. The service is of high intensity with the intent to develop effective behavioral strategies that will be maintained and help the recipient to sustain the behavioral strategies long-term.

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

N/A

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

(Choose each that applies):

☑ Categorically needy *(specify limits):*

The amount, frequency and duration of this service is based on the recipients' assessed needs and documented in the approved participant service plan/PCSP.

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

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

☐ Medically needy *(specify limits):*

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

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

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

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

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

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

Participant-Direction of Services

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

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. **Service plans 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, including the use of restraints.**

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

Requirement	***1a. Service plans address assessed needs of 1915(i) participants***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of service plans reviewed that adequately address the assessed needs of 1915(i) recipients. N = Number of service plans reviewed that adequately address the assessed needs of 1915(i) recipients. D = Total number of service plans reviewed.
Discovery Activity *(Source of Data & sample size)*	Remote Desktop Record Reviews for 10% of all recipients active/inactive during review period.

Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency (SMA) Quality Assurance (QA) and Operating Agency
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Operating Agency and SMA will remediate any issue of noncompliance within 90 days of issuance of final monthly report. On a monthly basis, Operating Agency, and SMA's QA review random samples of case files. If deficiencies are found, Operating Agency will take action as needed through one-on-one education with their contract entity or trainings for the local non-state entities. Copies of the Operating Agency reviews will be submitted to the SMA's QA and current percentages of compliance, as well as remediations, will be discussed during the monthly QI meeting. QI Team consists of SMA's BHBC Unit and QA units, Operating Agency and Local Non-State Entities.
Frequency *(of Analysis and Aggregation)*	Monthly, Quarterly, Annually

Requirement	***1b. Service plans are updated annually***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of service plans that are updated at least once in the last 12 months. N = Number of service plans that are updated at least once in the last 12 months. D = Total number of service plans reviewed.
Discovery Activity *(Source of Data & sample size)*	Remote Desktop Record Reviews for 10% of all recipients active/inactive during review period.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency (SMA) Quality Assurance (QA) and Operating Agency
Frequency	Annually
Remediation	

Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Operating Agency and SMA will remediate any issue of noncompliance within 90 days of issuance of final monthly report. On a monthly basis, Operating Agency, and SMA's QA review random samples of case files. If deficiencies are found, Operating Agency will take action as needed through one-on-one education with their contract entity or trainings for the local non-state entities. Copies of the Operating Agency reviews will be submitted to the SMA's QA and current percentages of compliance, as well as remediations, will be discussed during the monthly QI meeting. QI Team consists of SMA's BHBC Unit and QA units, Operating Agency and Local Non-State Entities.
Frequency *(of Analysis and Aggregation)*	Monthly, Quarterly, Annually

Requirement	***1c. Service plans document choice of services and providers***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of service plans reviewed that indicate 1915(i) recipients/ person legally responsible (PLR) were given a choice when selecting services and providers. N = Number of service plans reviewed that indicate 1915(i) recipients/person legally responsible were given a choice when selecting services and providers. D = Total number of service plans reviewed
Discovery Activity *(Source of Data & sample size)*	Remote Desktop Record Reviews for 10% of all recipients active/inactive during review period.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency (SMA) Quality Assurance (QA) and Operating Agency
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required*	Operating Agency and SMA will remediate any issue of noncompliance within 90 days of issuance of final monthly report. On a monthly basis, Operating Agency, and SMA's QA review random samples of case files. If deficiencies are found, Operating Agency will take action as needed through one-on-one education with their contract entity or trainings for the local non-state entities. Copies of the Operating Agency reviews will be

timeframes for remediation)	submitted to the SMA's QA and current percentages of compliance, as well as remediations, will be discussed during the monthly QI meeting. QI Team consists of SMA's BHBC Unit and QA units, Operating Agency and Local Non-State Entities.
Frequency *(of Analysis and Aggregation)*	Monthly, Quarterly, Annually

Requirement	***2a. An evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of applicants who had an evaluation for 1915(i) needs-based eligibility criteria prior to receiving services. N: Number of evaluations completed prior to receiving services. D: Number of referrals for 1915(i) services received.
Discovery Activity *(Source of Data & sample size)*	Remote Desktop Record Reviews for 10% of all recipients active/inactive during review period.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency (SMA) Quality Assurance (QA) and Operating Agency
Frequency	Monthly, Quarterly and Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Operating Agency will advise the SMA QA of issues as they occur and will remediate any issues of non-compliance within 90 days. On a monthly basis, Operating Agency, and SMA QA random review samples of case files. If deficiencies are found, Operating Agency will take action as needed through one-on-one education with their contract entity or trainings for the local non-state entities. Copies of the Operating Agency reviews will be submitted to the SMA's QA and current percentages of compliance, as well as remediations, will be discussed during the monthly QI meeting. QI Team consists of SMA's BH Unit and QA units, Operating Agency and Local Non-State Entities.
Frequency	Monthly, Quarterly, Annually

(of Analysis and Aggregation)	

Requirement	***2b. The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of recipients whose eligibility were completed using the processes and instruments approved in the 1915(i) HCBS state plan. N = Number of recipients found eligible using the processes and instruments approved in the 1915(i) HCBS state plan. D = Total number of recipients with a 1915(i)-eligibility determination.
Discovery Activity *(Source of Data & sample size)*	Remote Desktop Record Reviews for 10% of all recipients active/inactive during review period.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency (SMA) Quality Assurance (QA) and Operating Agency
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Operating Agency and SMA will remediate any issue of noncompliance within 90 days of issuance of final monthly report. On a monthly basis, Operating Agency and SMA's QA review random samples of case files. If deficiencies are found, Operating Agency will take action as needed through one-on-one education with their contract entity or trainings for the local non-state entities. Copies of the Operating Agency reviews will be submitted to the SMA's QA and current percentages of compliance, as well as remediations, will be discussed during the monthly QI meeting. QI Team consists of SMA's BH Unit and QA units, Operating Agency and Local Non-State Entities.
Frequency *(of Analysis and Aggregation)*	Monthly, Quarterly, Annually

Requirement	***2c.* the 1915(i)-benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percentage of enrolled recipients whose 1915(i)-benefit eligibility Criteria, was reevaluated annually. N=Number of enrolled recipients whose 1915(i)-benefit eligibility was reevaluated annually D=Number of enrolled recipients reviewed.
Discovery Activity *(Source of Data & sample size)*	Remote Desktop Record Reviews for 10% of all recipients active/inactive during review period.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency (SMA) Quality Assurance (QA) and Operating Agency
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Operating Agency and SMA will remediate any issue of noncompliance within 90 days of issuance of final monthly report. On a monthly basis, Operating Agency and SMA's QA review random samples of case files. If deficiencies are found, Operating Agency will take action as needed through one-on-one education with their contract entity or trainings for the local non-state entities. Copies of the Operating Agency reviews will be submitted to the SMA's QA and current percentages of compliance, as well as remediations, will be discussed during the monthly QI meeting QI Team consists of SMA's BH Unit and; QA units, Operating Agency and Local Non-State Entities
Frequency *(of Analysis and Aggregation)*	Quarterly, Annually, Continuously and Ongoing

Requirement	**3. *Providers meet required qualifications***
Discovery	
Discovery Evidence	Number and percent of 1915(i) providers who meet the State's provider qualifications, as required, prior to providing 1915(i) services.

(Performance Measure)	N= Number of 1915(i) providers who meet the State's provider qualifications, as required, prior to providing 1915(i) services. D=Total number of 1915(i) providers reviewed.
Discovery Activity *(Source of Data & sample size)*	Remote Desktop Record Reviews for 100% of all Providers active/inactive during review period.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA BH Unit, SMA Provider Enrollment Unit and SMA Fiscal Agent and operating agency
Frequency	Initially Upon Enrollment and re-validation
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Operating Agency and SMA will remediate any issue of noncompliance within 30 days. All provider enrollment applications and revalidations are submitted electronically through the Provider Portal. 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, Annually or on re-validation schedule

Requirement	**4. *Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).***
Discovery	
Discovery Evidence *(Performance Measure)*	The total number of providers whose setting, prior to authorization and ongoing, meets the recipient's needs in home and community-based settings requirements in accordance with 42 CFR 441.710(a)(l) and (2). N=Number of providers reviewed whose settings meet Federal HCBS settings requirements prior to enrollment and ongoing. D= Total number of providers reviewed
Discovery Activity	Remote Desktop/ On Site Record Reviews for 100% of all active settings during a review period.

(Source of Data & sample size)	
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA BH Unit, Operating Agency, Local Non-State Entities
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Operating Agency and SMA will remediate any issue of noncompliance within 30 days.
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	**5.** ***The SMA retains authority and responsibility for program operations and oversight.***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of Program Analytics report(s) received from HHS Analytics Team. N= Number of reports received by SMA. D= Total Number of Utilization Reports
Discovery Activity *(Source of Data & sample size)*	Reports are provided to the SMA BHBC Unit by the HHS Analytics. The purpose of this report is to review the utilization and spend of coverage for services for the Specialized Foster Care (SFC) population associated with a 1915(i) State Plan Option, including Intensive In-Home Supports and Services and Crisis Stabilization Services
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA BH Unit; HHS Analytics Team
Frequency	Quarterly

Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA BH Unit; Operating Agency The SMA will review the aggregate report due by HHS Analytics. HHS Analytics aggregates data provided by DCFS/Operating Agency for 1915(i) HCBS Services. SMA will review report with Operating Agency and will remediate any discrepancies and/or issue of noncompliance within 60 days of receipt of report. The purpose of this report is to review the utilization and spend of coverage for services for the Specialized Foster Care (SFC) population associated with a 1915(i) State Plan Option, including Intensive In-Home Supports and Services and Crisis Stabilization Services.
Frequency *(of Analysis and Aggregation)*	Quarterly, Annually

Requirement	**6. *The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of claims paid to 1915(i) service providers who are qualified to furnish 1915(i) services to 1915(i) participants. N: Number of claims paid to 1915(i) service providers who are qualified to furnish 1915(i) services to 1915(i) participants. D: Number of claims submitted during the review period.
Discovery Activity *(Source of Data & sample size)*	Remote Desktop Financial Record Reviews for 10% of all paid claims during review period within a randomized month for selected participants.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA Quality Assurance
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and*	The SMA QA will provide issues and discrepancies found within the randomly selected month's billings to the SMA's Surveillance and Utilization Review (SUR) unit to review and determine extent of issue.

aggregates remediation activities; required timeframes for remediation)	SMA SUR will remediate any issue of non-compliance within 12 Months of notification by using Recoupment or Letters of Instructions.
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***6b. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of claims verified through a review of provider documentation that have been paid in accordance with the individual's service plan. N=Number of claims verified through a review of provider documentation that have been paid in accordance with the individual's service plan. D= Total number of claims reviewed.
Discovery Activity *(Source of Data & sample size)*	Remote Desktop Financial Record Reviews for 10% of all paid claims during review period within a randomized month for selected participants.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA Quality Assurance
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA QA will provide issues and discrepancies found within the randomly selected month's billings to the SMA's Surveillance and Utilization Review (SUR) unit to review and determine extent of issue. SMA SUR will remediate any issue of non-compliance within 12 Months of notification by using Recoupment or Letters of Instructions.
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***7a. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation.***
Discovery	
Discovery Evidence *(Performance Measure)*	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 recipient service plans/ PCSPs reviewed.
Discovery Activity *(Source of Data & sample size)*	Remote Desktop Record Reviews for 10% of all recipients active/inactive during review period.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA QA, SMA BH Unit, Operating Agency
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Operating Agency and SMA will remediate any issue of noncompliance within 30 days of receiving the report. During the initial and annual assessment, potential and existing recipients and their legal guardians/caregivers will be educated on how to report critical incidents. Standard documentation will indicate they are given information on how to report and provided a list of contacts for reporting. The verification of education will be kept in the case file for review as requested by SMA and operating agency. QI Team consists of SMA's BH Unit and QA units, and Operating Agency
Frequency *(of Analysis and Aggregation)*	Monthly, Quarterly, Annually

Requirement	***7b.* The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation.**
Discovery	
Discovery Evidence	Serious Occurrences that were reported or remediated in accordance with the requirements of the 1915(i).

	(Performance Measure)	N: Number of Serious Occurrences that were reported or remediated in accordance with the requirements of the 1915(i). D: Total number of Serious Occurrences reported.
	Discovery Activity *(Source of Data & sample size)*	Remote Desktop Record Reviews for 100% of all recipients active/inactive during review period.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA BH Unit, Local Non-State Entities, Operating Agency
	Frequency	Monthly, Continuously and Ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Operating Agency and SMA will remediate any issue or non-compliance within 30 days of receipt of SORs report. All Serious Occurrence Reports (SOR) must be reported within timeframes outlined in Administering and Operating Agency's policies and procedures. Within 5 business days of notification of an incident, Care Coordinators will conduct all necessary follow-ups to include plan of correction, report submitted to law enforcement, CPS or Health Care Quality and Compliance (HCQC) if applicable. All SORs are entered into an approved SORs database, including follow-ups by Care Coordinators and/ or Case Workers. Operating Agency will review and approve follow-ups to ensure appropriate action is taken, and the health and safety of the recipients have been addressed timely. Reports on all SOR activity for 1915(i) recipients is generated by the Operating Agency, on a monthly basis, and provide to the SMA for reporting.
	Frequency *(of Analysis and Aggregation)*	Monthly, 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 Operating Agency's designated Care Coordinators and Supervisors, Operating Agency QA, SMA QA, SMA BHBC Unit will 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 Operating Agency regarding how to perform case file and provider reviews. Provider reviews are entered into the provider 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 which provide data needed for QA 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 are also done through InterChange, which has built-in edits to ensure claims are processed correctly and appropriately.

2. Roles and Responsibilities

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

QI Team participates in monthly and quarterly comprehensive QI meetings.

3. Frequency

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

4. Method for Evaluating Effectiveness of System Changes

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

Methods and Standards for Establishing Payment Rates

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

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

A. Providers of Home and Community Based Services:

1. Payment for services is the amount specified on the Nevada Medicaid Fee Schedule. All rates are published on our website: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/ and is effective for services provided on or after July 1, 2025. Except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers.

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