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State/Territory Name: Nevada

State Plan Amendment (SPA) #: 25-0032

This file contains the following documents in the order listed:

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



Medicaid and CHIP Operations Group

March 4, 2026

Stacie Weeks, Director
Nevada Health Authority
Nevada Medicaid
4070 Silver Sage Drive
Carson City, NV 89701

RE: Nevada 25-0032 §1915(i) home and community-based services (HCBS) state plan amendment (SPA)

Dear Director Weeks:

The Centers for Medicare & Medicaid Services (CMS) is approving the state's request to amend its 1915(i) state plan home and community-based services (HCBS) benefit, transmittal number TN # 25-0032. The effective date for this amendment is March 4, 2026. With this amendment, the state will rename Crisis Stabilization Services to Family Stabilization and revise the definition to reflect the habilitative service designed to support at-risk youth. Additionally, the Nevada Health Authority will replace the term Qualified Mental Health Professional with Licensed Professionals.

Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Attachment 3.1-i.2 pages, 1, 4, 8-9, 22, 25-28, 39-40
- Attachment 4.19b pages 18-18a

It is important to note that CMS' approval of this change to the state's 1915(i) HCBS state plan benefit solely addresses the state's compliance with the applicable Medicaid authorities. CMS' approval does not address the state's independent and separate obligations under federal laws including, but not limited to, the Americans with Disabilities Act, 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: Cecilia Williams, CMCS, CMS
Deanna Clark, CMCS, CMS
Blake Holt, CMCS, CMS
Cynthia Nanes, CMCS, CMS

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER
2 5 — 0 0 3 2

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
~~January 1, 2026~~ **March 4, 2026**

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR Part 430-456; 42 CFR § 440.180
42 CFR § 430.12; 42 CFR § 441.710

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a FFY 2026 \$ 0
b FFY 2027 \$ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-1-2; Pages 1, 4, 8-9, 22, 25-28, and 39-40
Attachment 4.19b pgs 18-18a

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)
Attachment 3.1-1-2; Pages 1, 4, 8-9, 22, 25-28, and 39-40
Attachment 4.19b pgs 18-18a

9. SUBJECT OF AMENDMENT
Updates include replacing legacy agency names with "NV Medicaid," renaming CSS to FSS with a revised definition to emphasize habilitative support for at-risk youth, and replacing "QMHP" with "Licensed Professionals and QMHPS" per NVHA updated terminology.

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, ASSPECIFIED:

12. TYPED NAME
STACIE WEEKS

13. TITLE
DIRECTOR, NVHA

14. DATE SUBMITTED
December 22, 2025

15. RETURN TO
Ann Jensen, Administrator
NVHA/Nevada Medicaid
4070 Silver Sage Drive
Carson City, NV 89701

FOR CMS USE ONLY

16. DATE RECEIVED
December 22, 2025

17. DATE APPROVED
March 4, 2026

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
March 4, 2026

19. SIGNATURE OF APPROVING OFFICIAL

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

21. TITLE OF APPROVING OFFICIAL
Director, Division of HCBS Operations & Oversight

22. REMARKS
CMS requested and received approval to make pen and ink changes to effective date March 4, 2026 for #4 of CMS 179, and all coverage and reimbursement pages for this SPA.

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. Family Stabilization Services

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

Select one:

<input checked="" type="checkbox"/>	Not applicable
<input type="checkbox"/>	Applicable
Check the applicable authority or authorities:	
<input type="checkbox"/>	<p>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 <i>voluntarily</i> elect to receive <i>waiver</i> and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. <i>Specify:</i></p> <p>(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);</p> <p>(b) the geographic areas served by these plans;</p> <p>(c) the specific 1915(i) State plan HCBS furnished by these plans;</p> <p>(d) how payments are made to the health plans; and</p> <p>(e) whether the 1915(a) contract has been submitted or previously approved.</p>
<input type="checkbox"/>	<p>Waiver(s) authorized under §1915(b) of the Act.</p> <p><i>Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:</i></p>
Specify the §1915(b) authorities under which this program operates (<i>check each that applies</i>):	
<input type="checkbox"/>	§1915(b)(1) (mandated enrollment to managed care)
<input type="checkbox"/>	§1915(b)(3) (employ cost savings to furnish additional services)

Acronym	Name	Entity	Entity Type
NVHA	Nevada Health Authority	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: NVHA/ SMA will provide oversight of DCFS and the Local Non-State Entities as they perform the Individual State Plan HCBS Enrollment.

Function 2: NVHA/ SMA will provide oversight of DCFS and the Local Non-State Entities performing Initial and re-evaluation of eligibility.

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

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

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

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

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

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

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

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

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 parties involved.
- 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 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:

The evaluation/reevaluation process includes the assessments and eligibility determination.

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 18-19 to evaluate an individual's eligibility for these 1915(i) benefits. The Care Coordinator also reviews clinical indicators of impaired functioning: Prior psychological assessment record, prior placement history, and prior treatment history. These assessments are conducted under the supervision of a Licensed Professional or QMHP.

- 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):*

NVHA, 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. NVHA 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):*

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 NVHA 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 NVHA 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 NVHA 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 - Nevada Health Authority	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):

<input type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> Provider managed
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Service Specifications (Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):

Service Title: **Family Stabilization Services**

Service Definition (Scope):

Family Stabilization Services (FSS) are short-term, outcome-oriented, and high intensity behavioral health services. These services focus on teaching vital new skills, to at risk youth, to assist in managing their behaviors and lives more effectively. FSS are identified on the Person-Centered Service Plan (PCSP) which outlines goals and services for recipients learning new skills following experiences in traumatic environments. The recipients’ home of origin lacked the provision of effective coping strategies, leaving them without the necessary skills to manage their emotions and distressing experiences. FSS is focused on developing effective behavioral methods prior to, during, and following a crisis. These services are delivered in individual, one-to-one sessions with the individual, foster family by a trained Qualified Mental Health Associate (QMHA), Licensed Professional, or Qualified Mental Health Professional (QMHP). Services can be rendered in the recipients’ home and community and designed to achieve family stabilization. The intent of the service is to. develop effective behavioral methods that can be sustained long-term.

Family Stabilization Services (FSS) 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 Family Financial Participation (FFP) for FSS does not include costs that are properly charged as Title IV-E administrative expenses. To ensure compliance with federal requirements, the state affirms that 1915(i) services do not include funds available under Title IV-E of the Social Security Act.

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 are based on the recipients’ assessed needs and documented in the approved participant service plan/PCSP.

Family Stabilization Services are delivered in individual, one-to-one sessions, by a QMHA under the direction of a Licensed Professional, or QMHP trained by a certified Specialized Foster Care Agency. These services are available in the youth’s home and community. The maximum number of service hours per day is 4 hours, with a limit of up to 40 hours per month. A Prior Authorization request is required for services exceeding 40 hours per month. Additional units of service may be authorized by Nevada Health Authority (NVHA), or their designee upon post-authorization review.

Medically needy (*specify limits*):

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

Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
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 NVHA’s fiscal agent and meet all required standards listed in the NVHA 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 <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>	Frequency of Verification <i>(Specify):</i>
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.
Service Delivery Method. <i>(Check each that applies):</i>		
<input type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> 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):*

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

Requirement	5. The SMA retains authority and responsibility for program operations and oversight.
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	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 <i>(Source of Data & sample size)</i>	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 Family Stabilization Services
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	SMA BH Unit; HHS Analytics Team
Frequency	Quarterly

Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	<p>SMA BH Unit; Operating Agency</p> <p>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.</p> <p>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 Family Stabilization Services.</p>
Frequency <i>(of Analysis and Aggregation)</i>	<p>Quarterly, Annually</p>

Requirement	<p>6. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.</p>
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	<p>Number and percent of claims paid to 1915(i) service providers who are qualified to furnish 1915(i) services to 1915(i) participants.</p> <p>N: Number of claims paid to 1915(i) service providers who are qualified to furnish 1915(i) services to 1915(i) participants.</p> <p>D: Number of claims submitted during the review period.</p>
Discovery Activity <i>(Source of Data & sample size)</i>	<p>Remote Desktop Financial Record Reviews for 10% of all paid claims during review period within a randomized month for selected participants.</p>
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	<p>SMA Quality Assurance</p>
Frequency	<p>Annually</p>
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and</i>	<p>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.</p>

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):*

<input type="checkbox"/>	HCBS Case Management	
<input type="checkbox"/>	HCBS Homemaker	
<input type="checkbox"/>	HCBS Home Health Aide	
<input type="checkbox"/>	HCBS Personal Care	
<input type="checkbox"/>	HCBS Adult Day Health	
<input type="checkbox"/>	HCBS Habilitation	
<input type="checkbox"/>	HCBS Respite Care	
For Individuals with Chronic Mental Illness, the following services:		
<input type="checkbox"/>	HCBS Day Treatment or Other Partial Hospitalization Services	
<input type="checkbox"/>	HCBS Psychosocial Rehabilitation	
<input type="checkbox"/>	HCBS Clinic Services (whether or not furnished in a facility for CMI)	
<input checked="" type="checkbox"/>	Other Services (specify below)	
	Family 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/> The fee schedule was last set on July 1, 2025, and is effective for services provided on or after that date. Except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers.