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

# Administration and Operation

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

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

1. Intensive In-Home Services and Supports
~~2. Supported Employment~~
~~3. Prevocational Services~~
~~4.~~ Crisis Stabilization Services
~~5. Planned Respite Services~~
~~6. Crisis Respite Services~~
~~7. Family/Caregiver Supports and Services~~
~~8.2. Non Medical Transportation~~

**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:*<br>*(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);*<br>*(b) the geographic areas served by these plans;*<br>*(c) the specific 1915(i) State plan HCBS furnished by these plans;*<br>*(d) how payments are made to the health plans; and*<br>*(e) whether the 1915(a) contract has been submitted or previously approved.* |
| | |
| ☐ | **Waiver(s) authorized under §1915(b) of the Act.**<br>*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*): |

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

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

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

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

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

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

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

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

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

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

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

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*(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):*

Nevada's vast geography, healthcare provider shortage, and lack of access to community-based providers contribute to the challenge of the addressing the behavioral health needs of vulnerable Nevadans. Nevada is the 7th largest state in the United States with a diverse population. Only 9.7% of the residents live in the 14 rural and frontier counties, which comprise almost 87% of the state's land mass. The remaining 90.3% of the population reside in the three urban counties. Some of the most significant health disparities in Nevada are based on socioeconomic status, primary language, race, gender identity, disability status, and sexual orientation. Health disparities and health provider shortages significantly impact rural, frontier and urban communities, and the health of these in these populations are negatively impacted by these shortages. Currently 67% of Nevada's population is in a primary care Health Professional Shortage Area (HPSA), while 72% of the state's population is in a dental health HPSA, and 94% of Nevada's population is in a mental health HPSA[CP1].[AJ2]

1) The Care Manager or Wraparound Facilitator is DCFS-authorized to perform evaluations, assessments, and develop plans of care. The Care Manager or Wraparound Facilitator is not authorized to provide direct services without prior approval from the QIO-like vendor employed by the DHCFP.

2) The QIO-like vendor, an independent State entity, is making the final eligibility determination and providing authorization for the Plan of Care (POC). The QIO-like vendor is not related by blood or marriage to the Applicant/Participant; to any of the individual's paid caregivers; or to anyone financially responsible for the individual or empowered to make financial or health related decisions on the Applicant/Participant's behalf. Additionally, the QIO-like vendor is not a provider of 1915(i) services.

3) DCFS will provide oversight for the Care Managers and Wraparound Facilitators by engaging in quality management activities to promote adherence to intensive care management, care coordination and wraparound service delivery practices, including family choice and direction in the development of the Plan of Care, selection of service providers and preference for service delivery. DCFS is responsible to provide training, education, site visits, record reviews and consultation to ensure provider compliance with DCFS requirements and standards. DHCFP will serve as an oversight body ensuring DCFS is performing all required quality management activities.

4) Participants and families are educated regarding their rights and how to submit grievances, complaints or appeals regarding all aspects of DCFS service delivery, providers, inclusion in treatment planning, eligibility determinations or POC authorization.

To ensure compliance with DCFS requirements the State will utilize a Governance Board comprised of family members, advocates, providers, community supports and state leadership (including representation from the DHCFP) to provide oversight of the State's DCFS Quality Improvement plan and performance measures. The board quarterly reviews the following:

1) Grievances, complaints, appeals and resulting decisions.

2) Performance measures, including identified problems with service utilization, provider practice and Participant outcomes.

3) Outcomes for quality improvement initiatives implemented to increase compliance with DCFS service delivery requirements and standards.

**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 [AJ3]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.

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## 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 | 1/1/2020 | 12/31/2020 | 950 |
| 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.

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## 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*):

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

## Evaluation/Reevaluation of Eligibility

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

| | |
|---|---|
| ○ | Directly by the Medicaid agency |

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

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

The Care Manager [AJ4]who is responsible for performing evaluation/reevaluation of eligibility must be independent and have one of the following qualifications:
Qualified Mental Health Associate (QMHA) –
A person who meets the following documented minimum qualifications:
1. Licensure as a Registered Nurse (RN) in the State of Nevada or holds a Bachelor's Degree from an accredited college or university in a human, social services or behavioral field with additional understanding of RMH treatment services and case file documentation requirements; or
2. Holds an associate's degree from an accredited college or university in a human, social services or behavioral field with additional understanding of RMH treatment services, and case file documentation and has four years of relevant professional experience of providing direct services to individuals with mental health disorders;
   or
3. An equivalent combination of education and experience as listed in 1-2 above; and
4. Whose education and experience demonstrate the competency under clinical supervision to:
   a. Direct and provide professional therapeutic interventions within the scope of their practice and limits of their expertise;
   b. Identify presenting problem(s);
   c. Participate in treatment plan development and implementation;
   d. Coordinate treatment;
   e. Provide parenting skills training;
   f. Facilitate discharge plans; and
   g. Effectively provide verbal and written communication on behalf of the recipient to all involved parties.
5. Has a Federal Bureau of Investigation (FBI) background check in accordance with the Qualified Behavioral Aides (QBA) provider qualifications listed under Section 403.6A of the Nevada MSM.

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

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

The following are also considered QMHPs:

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

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

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

A. diagnose, treat or prevent illness or disease;
B. regain functional capacity; or
C. reduce or ameliorate effects of an illness, injury or disability.

The determination of medical necessity is made on the basis of the individual case and takes into account:

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

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

The Wraparound Facilitator [AJ5]will be familiar with the medical necessity criteria and will use criteria and the individual's clinical history to facilitate the determination of eligibility.

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):*

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

1**. Impaired Functioning & Service Intensity**: The Wraparound Facilitator and CFT will use a comprehensive biopsychosocial assessment and a level of care decision support tool such as the Early Childhood Service Intensity Instrument (ECSII) for youth ages 0-5 or the Child and Adolescent Service Intensity Instrument (CASII) for youth ages 6-18. The Wraparound Facilitator and CFT will review clinical indicators of impaired functioning such as prior placement history and prior treatment history.

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.

Risk Factors include:

- ✓ Children and youth in treatment level care who have been disrupted from a placement within the past six months;
- ✓ Children and youth who are placed in emergency shelter or congregate care due to behavioral and mental health needs;
- ✓ Children and youth returning or stepping down from residential treatment centers or other higher level of care placements; and
- ✓ Prior less restrictive placements or interventions, such as traditional family foster care and/or community treatment services, have not been successful.

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

| **State plan HCBS needs-based eligibility criteria** | **NF (& NF LOC** waivers)** | **ICF/IID (& ICF/IID LOC waivers)** | **Applicable Hospital* (& Hospital LOC waivers)** |
|---|---|---|---|
| Children/youth must need minimum requirements to be considered for 1915(i) services:<br><br>1**. Impaired Functioning & Service Intensity**: The Wraparound Facilitator and CFT will use a comprehensive biopsychosocial assessment and a level | The assessment includes medical history pertinent to nursing facility placement, ability to safely self-administer medications; special needs such as durable medical equipment or frequency and duration of any treatments; the level of assistance (self-care, supervision, assistance, dependent) | In order to meet the ICF-IID level of care criteria, the individual must meet all of the following:<br>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 | Nevada does not have a hospital LOC waiver. However, for an individual to be eligible for services in a Hospital, the individual must have continuous need of facilities, services, equipment and medical personnel for prevention, diagnosis, or treatment of acute illness or injury |



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| of care decision support tool such as the Early Childhood Service Intensity Instrument (ECSII) for youth ages 0-5 or the Child and Adolescent Service Intensity Instrument (CASII) for youth ages 6-18. The Wraparound Facilitator and CFT will review clinical indicators of impaired functioning such as prior placement history and prior treatment history.<br><br>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.<br><br>Risk Factors include:<br>✓ Children and youth in treatment level care who have been disrupted from a placement within the past six months;<br>✓ Children and youth who are placed in emergency shelter or congregate care due to behavioral and mental health needs; | needed with activities of daily living (mobility, transfers, locomotion, dressing, eating, feeding, hygiene, bathing, bowel and bladder); need for supervision; ability to perform instrumental activities of daily living (meal preparation and homemaking services related to personal care). Additional consideration given to social history and current living environment, family (or other) support systems available, discharge planning information, potential risk of injury or danger to self or others. The assessment determines if the condition requires the level of services offered in a nursing facility with at least 3 functional deficits identified in sections 1-5 of the screening tool or a more integrated service which may be community based. The applicant/recipient would require imminent placement in a nursing facility (within 30 days) if Home and Community Based waiver services or other supports were not available. | independent living). For children age 6 yrs and younger, to have intensive support needs in areas of behavioral skills, general skills training, personal care, medical intervention, etc., beyond those required for children of the same age.<br>2. The individual has a diagnosis of an intellectual disability, or a related condition. The onset of an intellectual disability must have occurred before the age of 18, and the onset of a related condition must have occurred on or before age 22.<br>3. Must require monthly supports by, or under the supervision of, a health care professional or trained support personnel.<br>4. The monthly support may be from one entity or may be a combination of supports provided from various sources.<br>5. The individual cannot be maintained in a less restrictive environment without supports or services. Through the assessment process the team has identified the individual as being at risk of needing institutional placement (ICF/IID) without the provision of at least monthly supports. | certified by a physician. |

| ✓ Children and youth returning or stepping down from residential treatment centers or other higher level of care placements; and<br>~~1.~~✓ Prior less restrictive placements or interventions, such as traditional family foster care and/or community treatment services, have not been successful. | | | |
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*Long Term Care/Chronic Care Hospital

**LOC= level of care

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**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. Youth must meet all of the following:<br>✓✓ Youth must be under 19 years of age at the time of enrollment; they may continue in HCBS benefit up to age 19 if still enrolled in high school;<br>✓✓ Children for which the State of Nevada or county child welfare jurisdiction (Clark County Department of Family Services (CCDFS), Washoe County Human Services Agency (WCHSA)) is the legal custodian and who are admitted in the specialized foster care program;<br>✓✓ There must be clinical evidence the child or adolescent has a serious emotional disturbance (SED) and continues to meet the service intensity needs and medical necessity criteria for the duration of their enrollment; and<br>✓✓ Youth must have a Diagnostic and Statistical Manual of Mental Disorders (DSM-5) or Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-3) diagnosis. |
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☐ **Option for Phase-in of Services and Eligibility**[AJ6]. 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.**<br>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:<br>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**<br>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.)*

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

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

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# 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 Manager must be independent and have one of the following qualifications:

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

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

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

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

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

All Wraparound Facilitators will be required to be certified by DCFS as a Wraparound Facilitator utilizing the standards of the National Wraparound Implementation Center.

All Care Managers and Wraparound Facilitators will be required to maintain appropriate certifications including certification on the Nevada Child and Adolescent Needs and Strengths tool (NV-CANS).

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

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

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

The Care Manager or Wraparound Facilitator will utilize assessments to create the individualized POC for children and families. The plan will include needs, outcomes, and strategies that are:

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

The person-centered POC will include detailed service plans for applicable 1915(i) services~~. All~~ [AJ7]~~children will have Crisis Stabilization, Planned Respite, and Crisis Respite plans included as part of the POC.~~

The CFT shall develop the initial POC, which will be documented by the Care Manager or Wraparound Facilitator. The Care Manager or Wraparound Facilitator will also be responsible for documenting updates to the POC, including recommendations and decisions made by the CFT, in accordance to timeframes as listed in DCFS policy.

The Care Manager is responsible to submit the developed POC to the QIO-like vendor for approval.

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

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

Within ~~48~~ 72 hours of notification of enro[AJ8][AJ9]llment, the Care Manager contacts the participant and family to schedule a face-to-face meeting. At the first meeting between the Wraparound Facilitator, participant, and family after enrollment, the Wraparound Facilitator will:
(a) Administer the appropriate assessments, as designated by DCFS;
(b) Work with the participant and family to develop an initial crisis plan that includes response

to immediate service needs;
(c) Execute signing of releases of information and all necessary consents
(d) Provide an overview of the wraparound process; and
(e) Facilitate the family sharing their story.

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

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

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

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

7. **Informed Choice of Providers.** *(Describe* [AJ10]*how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

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

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

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

DHCFP, through an Interlocal agreement with DCFS, delegates the responsibility for service plan approval to an independent contracted entity (QIO-like vendor). As part of its routine operations, DHCFP's contracted entity, must review each service plan submitted to ensure the plan addresses all pertinent issues identified through the assessment. The DHCFP contractor enters the determination of his/her review in the Provider Portal database. The Provider Portal database interfaces with the Medicaid Management Information System for processing and tracking of eligible individuals, 1915 i services and claims reimbursements. The DHCFP contractor informs DHCFP and DCFS of any issues related to the review and approval or denial of service plans. DHCFP retains the authority and oversight of the 1915(i) program delegated to DCFS. In addition, the [NAME] reviews and approves the policies, processes and standards for developing and approving [AJ11][AJ12]the care plan.

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

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

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

## Services

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

| ~~**Service Specifications** *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*~~ | |
|---|---|
| ~~Service Title:~~ | ~~**Intensive Care Management Services**~~[AJ13] ~~**and/or Care Coordination Services**~~ |
| ~~Service Definition (Scope):~~ | |
| | |
| ~~Additional needs-based criteria for receiving the service, if applicable *(specify)*:~~ | |
| ~~N/A~~ | |



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<table>
<tr><td colspan="4">Specify limits (if any) on the amount, duration, or scope of this service.<br>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):</td></tr>
<tr><td>☑</td><td colspan="3">Categorically needy (specify limits):</td></tr>
<tr><td></td><td colspan="3"></td></tr>
<tr><td>☐</td><td colspan="3">Medically needy (specify limits):</td></tr>
<tr><td></td><td colspan="3">N/A</td></tr>
<tr><td colspan="4">Provider Qualifications (For each type of provider. Copy rows as needed):</td></tr>
<tr><td>Provider Type (Specify):</td><td>License (Specify):</td><td>Certification (Specify):</td><td>Other Standard (Specify):</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="4">Verification of Provider Qualifications (For each provider type listed above. Copy rows as needed):</td></tr>
<tr><td>Provider Type (Specify):</td><td colspan="2">Entity Responsible for Verification (Specify):</td><td>Frequency of Verification (Specify):</td></tr>
<tr><td></td><td colspan="2"></td><td></td></tr>
<tr><td></td><td colspan="2"></td><td></td></tr>
<tr><td></td><td colspan="2"></td><td></td></tr>
<tr><td colspan="4">Service Delivery Method. (Check each that applies):</td></tr>
<tr><td>☐</td><td>Participant-directed</td><td>☑</td><td>Provider managed</td></tr>
</table>

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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: | **Intensive In-Home Supports and Services** |
|---|---|

Service Definition (Scope):

Intensive In-Home Supports and Services include:

- ~~1.~~✓ Evidence-based interventions that target emotional, cognitive, and behavioral functioning within a variety of actual and/or simulated social settings. Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence. Services focus on enabling the participant to attain or maintain his or her maximum potential and shall be coordinated with any needed therapies, such as individual or family therapy, physical, occupational, or speech therapy, in the participant's person-centered services and support plans.
- ~~1.~~✓ Regular support and technical assistance to the treatment parents in their implementation of the POC and with regard to other responsibilities they undertake. The fundamental components of technical assistance are the design or revision of in-home treatment strategies including proactive goal setting and planning, the provision of ongoing child-specific skills training and the problem-solving during home visits.
- ~~2.~~✓ Assessing behavioral problems and the functions of these problems and related skill deficits and assets, including identifying primary and other important caregiver skill deficits and assets related to the youth's behaviors and the interactions that motivate, maintain, or improve behavior.

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

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

N/A

Specify limits (if any) on the amount, duration, or scope of this service.

Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*

☑ Categorically needy *(specify limits):*

The amount, frequency and duration of this service is based on the participant's assessed needs and documented in the approved POC. Eligible setting includes the child's home.

Service Limitations: Intensive In-Home Services and Supports Without Coaching – Maximum of 2 hours per day, 7 days a week.

Service Limitations: Intensive In-Home Services and Supports With Coaching – Maximum of 1 hour per week.

☐ Medically needy *(specify limits):*

N/A

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

| **Verification of Provider Qualifications** (*For each provider type listed above. Copy rows as needed)*: | | |
|---|---|---|
| Provider Type *(Specify)*: | Entity Responsible for Verification *(Specify):* | Frequency of Verification *(Specify):* |
| Intensive Home-based provider | Operating Agency – Division of Health Care Financing and Policy | Provider contract is effective for 60 months from enrollment date of its issuance and may be renewed upon expiration date. |

| | | |
|---|---|---|
| Specialized Foster Care Agency | Operating Agency – Division of Child and Family Services | Pursuant to NRS 424, an application for a license to operate a foster care agency must be in a form prescribed by the Division and submitted to the appropriate licensing authority. Such a license is effective for 2 years after the date of its issuance and may be renewed upon expiration. |
| Child Welfare Jurisdiction | Operating Agency – Division of Health Care Financing and Policy | Provider contract is effective for 60 months from enrollment date of its issuance and may be renewed upon expiration date. |

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

| | | | |
|---|---|---|---|
| ☐ | Participant-directed | ☑ | Provider managed |

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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:~~ | ~~**Supported Employment**~~ |
| ~~Service Definition (Scope):~~ | |

~~Supported employment services are individually designed to prepare a participant with serious emotional disturbance (SED) age 14 or older to engage in paid work.~~

~~**Supported Employment - Individual:** Individual supported employment services are services for participants who, due to their SED, need intensive, ongoing supports in order to obtain and maintain a job in competitive, customized employment, or self-employment, in an integrated work setting within the general workforce for which the individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without SED.~~

~~The outcome for this service is for an individual to obtain sustained employment, paid at or above minimum wage, in an integrated setting within the general workforce that meets personal and career goals. Supported employment is individualized and may include any combination of the following services: vocational, job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, training and systematic instruction, job coaching, benefit supports, training and planning, transportation training, asset development and career advancement services, and other workplace support services not specifically related to job skill training that enable the participant to be successful in an integrated work setting.~~

| |
|---|
| ~~**Supported Employment - Small Groups**: Small group supported employment services are services and training activities provided in regular business, industry and community settings with two (2) to eight (8) participants with SED. Examples include mobile crews, and other businesses employing small groups of participants with SED, for work within the community. Small group employment supports must be provided in a manner that promotes integration in the workplace and interaction between participants and people without SED within those workplaces.~~<br><br>~~The outcome of this service is for participants to obtain sustained, paid employment and work experience leading to further career development and integrated, community-based employment for which a participant is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without SED. Small group employment does not include vocational services provided in a facility-based work setting. Small group employment supports may include any combination of the following services: vocational, job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, training and systematic instruction, job coaching, benefit supports, training and planning, transportation training, career advancement services, and other workplace support services not specifically related to job skill training that enable the participant to be successful in an integrated work setting.~~<br><br>~~**Supported Employment - Customized**: Customized employment services individualizes employment relationships between employees and employers in ways that meet the needs of both. It is based on an individualized determination of the strengths, needs and interests of the participant with SED and is also designed to meet the specific needs of the employer. Customized employment assumes the provision of reasonable accommodations and support necessary to perform the functions of a job that is individually negotiated and developed.~~<br><br>~~Information is maintained in the file of each individual receiving this service; documenting that the service is not available in a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).~~<br><br>~~The Wraparound Facilitator develops a Detailed Service Plan which is part of the POC that identifies the goals, reasons for the goals, the intervention strategies to help achieve the goals and what the service provider will do to plan for goal accomplishment.~~[AJ14] |
| ~~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.~~<br><br>~~*(Choose each that applies)*:~~ |
| ☑ ~~Categorically needy *(specify limits)*:~~ |

| | |
|---|---|
| | ~~Participants who receive supported employment services may include two or more types of non-residential support services; however, individual and group services cannot be billed as overlapping services. Providers of this service must not reside in the SFC home where the child resides.~~<br><br>~~The amount, frequency and duration of this service is based on the child's assessed needs and documented in the approved POC.~~<br><br>~~Supported Employment Services may be provided in a variety of settings, particularly work sites. Supported Employment Services does not include facility based, or other similar types of vocational services furnished in specialized facilities that are not a part of the general workplace.~~<br><br>~~Supported Employment Individual Services also does not include working in mobile work crews of small groups of people with SED in the community or volunteer work. Supported Employment Services are provided at job sites for example stores, restaurants, or any place of business.~~<br><br>~~Supported Employment services may only be billed in one-hour units/increments for both individual and group sessions. Individual sessions will be paid at a higher rate than group sessions.~~<br><br>~~The maximum number of service hours per day is 4 hours, 3 days per week.~~<br><br>~~Federal financial participation cannot be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:~~<br><br>~~1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or~~<br><br>~~2. Payments that are passed through to users of supported employment services.~~ |
| ☐ | ~~Medically needy *(specify limits):*~~ |
| | ~~N/A~~ |

| ~~**Provider Qualifications** *(For each type of provider. Copy rows as needed)*:~~ | | | |
|---|---|---|---|
| ~~Provider Type *(Specify):*~~ | ~~License *(Specify):*~~ | ~~Certification *(Specify):*~~ | ~~Other Standard *(Specify):*~~ |
| ~~Supported Employment providers~~ | ~~Meet licensure requirements pursuant to DHCFP Medicaid Services Manual.~~ | ~~Meet certification requirements of DCFS.~~ | ~~Meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to DHCFP Medicaid Services Manual, Chapter 100.~~<br><br>~~Meet all Conditions of Participation in Medicaid Services Manual 102.1.~~ |
| ~~Specialized Foster Care Agency~~ | ~~Pursuant to NRS 424, an application for a license to operate a foster~~ | ~~Meet certification requirements of DCFS.~~ | ~~Meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to DHCFP Medicaid Services Manual, Chapter 100.~~ |

| | | | |
|---|---|---|---|
| | ~~care agency must be in a form prescribed by the Division and submitted to the appropriate licensing authority.~~ | | ~~Meet all Conditions of Participation in Medicaid Services Manual 102.1.~~<br><br>~~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*):~~ |
| ~~Supported Employment providers~~ | ~~Operating Agency – Division of Health Care Financing and Policy~~ | ~~Provider contract is effective for 60 months from enrollment date of its issuance and may be renewed upon expiration date.~~ |
| ~~Specialized Foster Care Agency~~ | ~~Operating Agency – Division of Child and Family Services~~ | ~~Pursuant to NRS 424, an application for a license to operate a foster care agency must be in a form prescribed by the Division and submitted to the appropriate licensing authority. Such a license is effective for 2 years after the date of its issuance and may be renewed upon expiration.~~ |

| ~~**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:~~ | ~~**Prevocational Services**~~ |
| ~~Service Definition (Scope):~~ | |

| |
|---|
| ~~Prevocational services are individually designed to prepare a participant age 14 or older with SED to engage in paid work. Services that provide learning and work experiences, including volunteer work, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Pre-vocational services include activities that are not primarily directed at teaching skills to perform a particular job, but at underlying habilitative goals (e.g., attention span, motor skills, interpersonal relations with co-workers and supervisors) that are associated with building skills necessary to perform compensated work in community integrated employment. Services are expected to occur over a defined period to time and with specific outcomes to be achieved, as identified in the participant's POC.~~<br><br>~~Participants receiving prevocational services must have employment-related goals in their person-centered POC; the general habilitative activities must be designed to support such employment goals. Competitive, integrated employment in the community for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by participants without SED, is considered to be the optimal outcome of prevocational services.~~<br><br>~~Prevocational services should enable each individual to attain the highest level of work in the most integrated setting and with the job matched to the individual's interests, strengths, priorities, abilities and capabilities, while following applicable federal wage guidelines. Services are intended to develop and teach general skills. Examples include, but are not limited to: an ability to communicate effectively with supervisors, coworkers and customers; generally accepted community workplace conduct and dress; an ability to follow directions; an ability to attend to tasks; workplace problem solving skills and strategies; and workplace safety and mobility training.~~<br><br>~~Prevocational services are designed to create a path to integrated, community-based employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by participants without SED.~~ |
| ~~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.~~<br><br>~~*(Choose each that applies)*:~~ |
| ☑ ~~Categorically needy *(specify limits)*:~~ |

| | |
|---|---|
| | ~~The amount, frequency and duration of this service is determined through an ongoing patient –centered planning process used to determine and assess the child's needs (while following applicable federal wage guidelines from the U.S. Department of Labor) and is documented in the POC and approved by the CFT team.~~<br><br>~~Participants who receive prevocational services may include two or more types of non-residential support services; however individual and group services cannot be billed as overlapping services.~~<br><br>~~The service may be provided outside [AJ15]of the foster care home in the community or a worksite. Prevocational services do not include vocational services provided in facility-based work settings that are not integrated settings in the general community workforce.~~<br><br>~~Prevocational Services may only be billed in one-hour units/increments for both Individual and group sessions. Individual sessions will be paid at a higher rate than group sessions.~~<br><br>~~The maximum number of service hours per day is 4 hours, 3 days a week.~~ |
| ☐ | ~~Medically needy *(specify limits)*:~~ |
| | ~~N/A~~ |

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

| ~~Provider Type *(Specify)*:~~ | ~~License *(Specify)*:~~ | ~~Certification *(Specify)*:~~ | ~~Other Standard *(Specify)*:~~ |
|---|---|---|---|
| ~~Prevocational service providers~~ | ~~Meet licensure requirements pursuant to DHCFP Medicaid Services Manual.~~ | ~~Service to be provided at a minimum by a QBA.~~<br><br>~~Meet certification requirements of DCFS.~~ | ~~Meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to DHCFP Medicaid Services Manual, Chapter 100.~~<br><br>~~Meet all Conditions of Participation in Medicaid Services Manual 102.1.~~ |
| ~~Specialized Foster Care Agency~~ | ~~Pursuant to NRS 424, an application for a license to operate a foster care agency must be in a form prescribed by the Division and submitted to the appropriate licensing authority. Such a license is effective for 2~~ | ~~Service to be provided at a minimum by a QBA.~~<br><br>~~Meet certification requirements of DCFS.~~ | ~~Meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to DHCFP Medicaid Services Manual, Chapter 100.~~<br><br>~~Meet all Conditions of Participation in Medicaid Services Manual 102.1.~~<br><br>~~Agencies must meet all applicable standards listed in NAC 424 and NRS 424.~~ |

| | | | |
|---|---|---|---|
| | years after the date of its issuance and may be renewed upon expiration. | | |

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

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

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

| Service Title: | **Crisis Stabilization Services** |
|---|---|

Service Definition (Scope)*:*

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

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

N/A

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

*(Choose each that applies):*

☑ Categorically needy *(specify limits):*

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

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

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

☐ Medically needy *(specify limits):*

N/A

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

| Provider Type *(Specify)*: | License *(Specify):* | Certification *(Specify):* | Other Standard<br>*(Specify):* |
|---|---|---|---|
| Specialized Foster Care Agency | Pursuant to NRS 424, an | QMHA under the direction of | Foster Care Agency providers must be enrolled as a Foster Care Provider |

| | | | |
|---|---|---|---|
| | 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. | a QMHP; QMHP | Agency through DHCFP's fiscal agent and meet all required standards listed in the DHCFP Medicaid Services Manual.<br><br>Agencies must meet all applicable standards listed in NAC 424 and NRS 424. |
| Child Welfare Jurisdiction | Meet licensure requirements pursuant to DHCFP Medicaid Services Manual. | QMHA under the direction of a QMHP; QMHP | Meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to DHCFP Medicaid Services Manual, Chapters 100 and 400. |

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

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

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

| | | | |
|---|---|---|---|
| ☐ | Participant-directed | ☑ | Provider managed |

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

| ~~Service Title:~~ | ~~**Planned Respite Services**~~ |
|---|---|

~~Service Definition (Scope):~~

~~Planned respite services are provided to participants because of the absence or need for relief of those persons who normally provide care for the participant. These short-term services are provided out of the home or in their home when the specialized foster care parent is unable to care for the participant or would benefit from a period of relief from caregiving.~~

~~Federal financial participation is not to be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the state that is not a private residence.~~

~~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 determined through an ongoing youth-centered planning process used to determine and assess the participant's needs, with specific outcomes to be achieved, and is documented in the approved POC.~~

~~Planned Respite is billed in 1 hour increments. This service is limited to 336 hours per recipient per year.~~

~~Service must be prior authorized by DHCFP or designee.~~

☐ ~~Medically needy *(specify limits):*~~

~~N/A~~

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

| ~~Provider Type *(Specify):*~~ | ~~License *(Specify):*~~ | ~~Certification *(Specify):*~~ | ~~Other Standard *(Specify):*~~ |
|---|---|---|---|
| ~~Respite Care Provider~~ | ~~Meet licensure requirements pursuant to DHCFP~~ | ~~Service to be provided at a minimum by a QBA or QMHA~~ | ~~Meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to DHCFP Medicaid Services Manual, Chapter 100.~~ |

| | | | |
|---|---|---|---|
| | ~~Medicaid Services Manual.~~ | ~~under the supervision of a QMHP.~~<br><br>~~Certification(s) required by DCFS.~~ | ~~Meet all Conditions of Participation in Medicaid Services Manual 102.1.~~ |
| ~~Specialized Foster Care Agency~~ | ~~Pursuant to NRS 424, an application for a license to operate a foster care agency must be in a form prescribed by the Division and submitted to the appropriate licensing authority.~~ | ~~Service to be provided at a minimum by a QBA or QMHA under the supervision of a QMHP.~~<br><br>~~Certification(s) required by DCFS.~~ | ~~Specialized 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.~~<br><br>~~Agencies must meet all applicable standards listed in NAC 424 and NRS 424.~~ |
| ~~Child Welfare Jurisdiction~~ | ~~Meet licensure requirements pursuant to DHCFP Medicaid Services Manual.~~ | ~~Service to be provided at a minimum by a QBA or QMHA under the supervision of a QMHP.~~<br><br>~~Certification(s) required by DCFS.~~ | ~~Meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to DHCFP Medicaid Services Manual, Chapters 100 and 400.~~ |

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

| ~~Provider Type (*Specify*):~~ | ~~Entity Responsible for Verification~~<br><br>~~(*Specify*):~~ | ~~Frequency of Verification (*Specify*):~~ |
|---|---|---|
| ~~Respite Services Provider~~ | ~~Operating Agency – Division of Health Care Financing and Policy~~ | ~~Provider contract is effective for 60 months from enrollment date of its issuance and may be renewed upon expiration date.~~ |
| ~~Specialized Foster Care Agency~~ | ~~Operating Agency – Division of Child and Family Services~~ | ~~Pursuant to NRS 424, an application for a license to operate a foster care agency must be in a form prescribed by the Division~~ |

| | | |
|---|---|---|
| | | ~~and submitted to the appropriate licensing authority. Such a license is effective for 2 years after the date of its issuance and may be renewed upon expiration.~~ |
| ~~Child Welfare Jurisdiction~~ | ~~Operating Agency – Division of Health Care Financing and Policy~~ | ~~Provider contract is effective for 60 months from enrollment date of its issuance and may be renewed upon expiration date.~~ |

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

| | |
|---|---|
| ~~**Service Specifications** *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*~~ | |
| ~~Service Title:~~ | ~~**Crisis Respite Services**~~ |
| ~~Service Definition (Scope):~~ | |
| ~~Crisis respite provides emergency short-term relief for family/caregivers (non-shift staff) needed to resolve a crisis and transition back to the child's successful functioning and engagement in POC activities. Crisis respite assists the family/caregivers in supporting the participant's SED and/or health care issues. These services can occur outside of or in the child's home.~~<br>~~Federal financial participation is not to be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the state that is not a private residence.~~ | |
| ~~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.~~<br>~~*(Choose each that applies):*~~ | |
| ☑ | ~~Categorically needy *(specify limits):*~~ |

| | |
|---|---|
| | This service may only be delivered in an individual, one-to-one session.<br><br>The amount, frequency and duration of this service is determined through an ongoing participant-centered planning process used to determine and assess the child's needs, with specific outcomes to be achieved, and is documented in the approved POC.<br><br>Crisis Respite is billed in 1 hour increments. Crisis respite care is limited to 720 hours per recipient per year. |
| ☐ | Medically needy *(specify limits)*: |
| | N/A |

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

| Provider Type *(Specify)*: | License *(Specify)*: | Certification *(Specify)*: | Other Standard *(Specify)*: |
|---|---|---|---|
| Respite Care Provider | Meet licensure requirements pursuant to DHCFP Medicaid Services Manual. | Service to be provided at a minimum by a QBA or QMHA under the supervision of a QMHP.<br><br>Certification(s) required by DCFS. | Meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to DHCFP Medicaid Services Manual, Chapter 100.<br><br>Meet all Conditions of Participation in Medicaid Services Manual 102.1. |
| Specialized Foster Care Agency | Pursuant to NRS 424, an application for a license to operate a foster care agency must be in a form prescribed by the Division and submitted to the appropriate licensing authority. | Service to be provided at a minimum by a QBA or QMHA under the supervision of a QMHP.<br><br>Certification(s) required by DCFS. | Meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to DHCFP Medicaid Services Manual, Chapter 100.<br><br>Meet all Conditions of Participation in Medicaid Services Manual 102.1.<br><br>Agencies must meet all applicable standards listed in NAC 424 and NRS 424. |
| Child Welfare Jurisdiction | Meet licensure requirements pursuant to DHCFP Medicaid Services | Service to be provided at a minimum by a QBA or QMHA under the supervision of a QMHP. | Meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to DHCFP Medicaid Services Manual, Chapters 100 and 400. |

| | | | |
|---|---|---|---|
| | Manual, Chapter 400. | Certification(s) required by DCFS.[AJ16] | |

| | | |
|---|---|---|
| **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*): |
| Respite Services Provider | Operating Agency – Division of Health Care Financing and Policy | Provider contract is effective for 60 months from enrollment date of its issuance and may be renewed upon expiration date. |
| Specialized Foster Care Agency | Operating Agency – Division of Child and Family Services | Pursuant to NRS 424, an application for a license to operate a foster care agency must be in a form prescribed by the Division and submitted to the appropriate licensing authority. Such a license is effective for 2 years after the date of its issuance and may be renewed upon expiration. |
| Child Welfare Jurisdiction | Operating Agency – Division of Health Care Financing and Policy | Provider contract is effective for 60 months from enrollment date of its issuance and may be renewed upon expiration date. |

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

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

Service Definition (Scope):

The Family Peer Support Specialist provides direct services to a family in a structured, one-to-one strength-based relationship that is culturally and linguistically appropriate. For the purposes of this service, "family" is defined as the persons who live with or provide care to a child served, and may include a parent, spouse, children, relatives, foster family, or in-laws. The purpose of the service is to increase the family's capacity to contribute to: (1) the reduction of the child's emotional and/or behavioral symptoms; (2) the improvement of the child's functioning; and (3) the promotion of the child's process of recovery. The Family Peer Support Specialist assists the family to develop coping and advocacy skills, problem-solving and parenting skills; and linkages with formal and informal community supports.

Family Peer Support Services may include:

1. **Emotional Support** provided through the facilitated sharing of experiences with the family and assistance in developing social connections to other families. Family Peer Support Specialists use self-disclosure and encouragement designed to address the family's isolation, shame, guilt and helplessness. The Family Peer Support Specialist also assists the family in identifying and developing social connections that may serve as informal supports to enhance the child and family's treatment planning and delivery process.

2. **Instructional Support** provided to coach the family on effective ways to address their child's disorder or associated behaviors as well as strategies to address the family's own personal well-being. Coaching activities may be directed at a family member's anger/anxiety/stress management skills; child and family crisis management; problem solving skills; communication skills; and behavior management skills.

3. **Advocacy Support** provided for the purpose of: (1) sharing specific information and materials about parental rights and resources (e.g., legislation, entitlements, and policy); (2) by coaching/ mentoring the family on advocacy, negotiation skills, and personal leadership skills; and (3) by providing direct advocacy on behalf of the child and family.

4. **Information and Referral Support** provided to family members on child behavior/development, children's behavioral health issues and their impact on the family, and treatment options. Family Peer Support Specialists provide information to the family on available child and family resources and assist the family in accessing services identified in the child's Care Coordination Plan, including application for TANF, Medicaid, housing, etc.

5. **Educational Support** provided to inform families about the educational process and to participate with family members in Individual Education Plan (IEP) and other school meetings that can improve the child's access to appropriate educational services that address their emotional and behavioral needs.

6. **Child and Family Team Support** provided when families are actively involved in wraparound. Family Peer Support Specialists attend Child and Family Team meetings to support the family in voicing issues, concerns and goals for their child and family that can be incorporated into a comprehensive POC. Family Peer Support Services are available to families as part of the aftercare plan[AJ17][MF18][AJ19]. Consistent with the best practice standards of the National Wraparound Initiative, Family Peer Support Specialists partner with the wraparound facilitator throughout the phases of wraparound care coordination to increase the fidelity and effectiveness of the process, completing agreed upon task and timelines.[AJ20]

~~Peer Support Services will be added to enhance the child's ability to function as part of a family and enhance the family's ability to care for the enrolled child. This will include, but may not be limited to:~~

~~Family and peer mentoring supports which will include:~~

- ~~Explain role and function of the Family Support Organization (FSO) to newly enrolled families and create linkages to other peers and supports in the community~~
- ~~Work with the family to identify and articulate their concerns, needs, and vision for the future of their child~~
- ~~Ensure family opinions and perspectives are incorporated throughout the CFT POC Process.~~
- ~~Attend CFT Team meetings with the family to support family decision making~~
- ~~Listen to the family express needs and concerns from peer perspective and offer options for engagement in the Wraparound process, CFT meetings and/or other Team meetings.~~
- ~~Provide ongoing emotional support, modeling and mentoring during all phases of the POC process~~
- ~~Help family identify and engage natural supports~~
- ~~Encourage the family to attend peer support groups and other FSO activities throughout POC process~~
- ~~Work with the family to organize, and prepare for meetings in order to maximize the family's participation in meetings~~
- ~~Inform the family about options and possible outcomes in selecting services and supports so they are able to make informed decisions for their child and family~~
- ~~Support the family in meetings at school, court and other locations in the community as appropriate~~
- ~~Assist the family in developing the skills and confidence to independently identify, seek out and access resources that will assist in managing and mitigating the child/youth's behavioral health condition(s), preventing the development of secondary or other chronic conditions, promoting optimal physical and behavioral health, and addressing and encouraging activities related to health and wellness~~
- ~~Assist the family identify and link to formal and informal supports~~
- ~~Assist the family in organizing and completing paperwork to secure needed supports~~
- ~~Educate the family on how to navigate systems of care for their children~~
- ~~Provide Family Peer Support as agreed to on the Plan of Care~~
- ~~Family training and empowerment services~~
    - ~~Through one-to-one training, help the family acquire the skills and knowledge needed to attain greater self- sufficiency and maximum autonomy~~
- ~~Participant education training and advocacy supports~~
    - ~~Through one-to-one training, help the participant acquire the skills and knowledge needed to attain greater self- sufficiency and maximum autonomy~~

~~Family may include birth families, kinship families, foster families, and pre-adoptive/adoptive families.~~

~~Based upon the family POC, that identifies the goals, reasons for the goals, the interventions strategies to help achieve the goals and what the service provider will do to plan for goal accomplishment, developed by the Team, this service provides opportunities to: interact and engage with family to offer educational, advocacy, and support resources to develop family's ability to independently access community services and activities, maintain and encourage the family's self-sufficiency in caring for the child in the home and community, address needs and issues of relevance to the family, and educate and train the family on resource availability so that they have what they need to support and advocate for the needs of the child and appropriately access needed services.~~

<table>
<tr><td colspan="5">Family Peer Support Services are provided face-to-face, by telephone and through electronic contacts with or on behalf of the family. The service is provided at the provider organization, in the home, in other community settings to provide accessibility for the family.</td></tr>
<tr><td colspan="5">Additional needs-based criteria for receiving the service, if applicable (specify):</td></tr>
<tr><td colspan="5">N/A</td></tr>
<tr><td colspan="5">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.<br><br>(Choose each that applies):</td></tr>
<tr><td rowspan="2">☑</td><td colspan="4">Categorically needy (specify limits):</td></tr>
<tr><td colspan="4">The service is automatically authorized for one year for any participant meeting the eligibility criteria of this 1915(i) State Plan Amendment. Thereafter, the services will be authorized in six month increments. The services provided under Family Peer Support may not be duplicative of other Public Mental Health System or HCBS benefit services. Family peer support may be provided, and billed, for meeting with the family in-person as well as for communicating with the family over the phone. Family peer support may not be billed for telephonic communications with other providers or resources.<br><br>Individual and Group services cannot be billed as overlapping services. The amount, frequency and duration of this service is based on the child's assessed needs and documented in the approved POC.<br><br>Peer Support Services begin upon agency or self[AJ21] CFT referral and end when the family determines they have reached their desired outcomes, ranging in duration from 9-24 months. The frequency of service is not limited and is determined through the Child and Family Team process and by direct family request.<br><br>Individual and Small Group Family Supports and Services are billed in 15 minute increments.<br><br>Service limits for family peer support as follows: 27 hours per month.</td></tr>
<tr><td rowspan="2">☐</td><td colspan="4">Medically needy (specify limits):</td></tr>
<tr><td colspan="4">N/A</td></tr>
<tr><td colspan="5">Provider Qualifications (For each type of provider. Copy rows as needed):</td></tr>
<tr><td colspan="2">Provider Type (Specify):</td><td>License (Specify):</td><td>Certification (Specify):</td><td>Other Standard<br><br>(Specify):</td></tr>
<tr><td colspan="2">Family Support Organization</td><td>Meet licensure requirements pursuant to DHCFP</td><td>The Family Support Organization ensures that Family Peer Support is</td><td>Approved by DCFS administration.</td></tr>
</table>

| | | | |
|---|---|---|---|
| | ~~Medicaid Services Manual.~~ | ~~provided by Certified Parent Support Providers (CPSP), through the national Federation of Families for Children's Mental Health Certification Commission or Certification Established by Nevada DCFS.~~<br><br>~~Individual providers:~~<br><br>~~1) High School diploma or GED~~<br>~~(2) Family member who has lived experience raising a child with emotional and behavioral needs~~<br>~~(3) Ability to pass criminal background checks~~<br>~~(4) Ability to complete training and orientation for the position~~<br>~~(5) Ability to satisfactorily complete on-going staff development~~<br>~~(6) Experience providing non-judgmental peer support and effective problem solving skills~~<br>~~(7) Certified as a Parent Support Provider (CPSP) by the National Federation of Families for Children's Mental Health; or supervised by a CPSP for up to two~~ | |

| | | years while obtaining CPSP certification<br><br>(8) Employed by a family run organization enrolled in Nevada's System of Care | |
|---|---|---|---|

| Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*): | | |
|---|---|---|
| Provider Type (*Specify*): | Entity Responsible for Verification<br><br>(*Specify*): | Frequency of Verification (*Specify*): |
| Family Support Organization | Operating Agency – Division of Health Care Financing and Policy | Provider contract is effective for 60 months from enrollment date of its issuance and may be renewed upon expiration date. |

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

| Service Specifications (*Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover*): | |
|---|---|
| Service Title: | **Non-medical transportation** |
| Service Definition (Scope): | |
| Non-Medical Transportation services are offered in order to enable 1915(i) SFC participants to gain access to community services, activities and resources, that are identified in the POC. Non-medical transportation services allow participants to engage in normal day-to-day, non-medical activities such | |

<table>
<tr><td colspan="5">~~as participating in social events and other civic activities or attending a worship service. Whenever possible, family, neighbors, friends or community agencies are utilized to provide this service without charge. This service is in addition to the medical transportation service offered under the Medicaid State Plan, which includes transportation to medical appointments and can be arranged at least 48 hours in advance, as well as for emergency medical transportation.~~<br><br>~~This service will not duplicate or impact the amount, duration and scope of the medical transportation benefit provided under the Medicaid State Plan.~~</td></tr>
<tr><td colspan="5">~~Additional needs-based criteria for receiving the service, if applicable *(specify)*:~~</td></tr>
<tr><td colspan="5">~~N/A~~</td></tr>
<tr><td colspan="5">~~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.~~<br><br>~~*(Choose each that applies)*:~~</td></tr>
<tr><td rowspan="2">☑</td><td colspan="4">~~Categorically needy *(specify limits)*:~~</td></tr>
<tr><td colspan="4">~~The amount, frequency and duration of this service is based on the participant's assessed needs and documented in the approved POC.~~<br><br>~~Non-medical transportation cannot exceed 2 times a week. Written authorization by the DHCFP is required for amounts in excess of the limit.~~</td></tr>
<tr><td rowspan="2">☐</td><td colspan="4">~~Medically needy *(specify limits)*:~~</td></tr>
<tr><td colspan="4">~~N/A~~</td></tr>
<tr><td colspan="5">~~**Provider Qualifications** *(For each type of provider. Copy rows as needed)*:~~</td></tr>
<tr><td colspan="2">~~Provider Type *(Specify)*:~~</td><td>~~License *(Specify)*:~~</td><td>~~Certification *(Specify)*:~~</td><td>~~Other Standard *(Specify)*:~~</td></tr>
<tr><td colspan="2">~~Transportation agency or individual~~</td><td>~~Possess a valid Nevada Driver's License.~~</td><td>~~QBA required at a minimum.~~</td><td>~~Meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to DHCFP Medicaid Services Manual, Chapter 100.~~<br><br>~~Meet all Conditions of Participation in Medicaid Services Manual 102.1.~~<br><br>~~Possess proof of Driver's Liability Insurance.~~</td></tr>
<tr><td colspan="2">~~Specialized Foster Care Agency~~</td><td>~~Possess a valid Nevada Driver's License.~~</td><td>~~QBA required at a minimum.~~</td><td>~~Meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to DHCFP Medicaid Services Manual, Chapter 100.~~</td></tr>
</table>

| | | | |
|---|---|---|---|
| | | | ~~Meet all Conditions of Participation in Medicaid Services Manual 102.1.~~<br><br>~~Agencies must meet all applicable standards listed in NAC 424 and NRS 424.~~<br><br>~~Possess proof of Driver's Liability Insurance.~~ |
| ~~Child Welfare Jurisdiction~~ | ~~Possess a valid Nevada Driver's License.~~ | ~~QBA required at a minimum.~~ | ~~Meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to DHCFP Medicaid Services Manual, Chapter 100.~~<br><br>~~Meet all Conditions of Participation in Medicaid Services Manual 102.1.~~<br><br>~~Possess proof of Driver's Liability Insurance.~~ |

| ~~**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*):~~ |
| ~~Transportation agency or individual~~ | ~~Operating Agency – Division of Health Care Financing and Policy~~ | ~~Provider contract is effective for 60 months from enrollment date of its issuance and may be renewed upon expiration date.~~ |
| ~~Specialized Foster Care Agency~~ | ~~Operating Agency – Division of Health Care Financing and Policy~~ | ~~Provider contract is effective for 60 months from enrollment date of its issuance and may be renewed upon expiration date.~~ |
| ~~Child Welfare Jurisdiction~~ | ~~Operating Agency – Division of Health Care Financing and Policy~~ | ~~Provider contract is effective for 60 months from enrollment date of its issuance and may be renewed upon expiration date.~~ |
| ~~**Service Delivery Method.** (*Check each that applies*):~~ | | |

| | Participant-directed | | Provider managed |
|---|---|---|---|

**2.** ☐ *(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):*

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# Participant-Direction of Services

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

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

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

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

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

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

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

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

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

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

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

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

7. **Volu[AJ23]ntary 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.):* |
| | |

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| **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.* |
| --- |
| |

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# Quality Improvement Strategy

**Quality Measures**

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

1. Plan of Care a) address assessed needs of 1915(i) participants; b) are updated annually; and (c document choice of services and providers.
2. Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.
3. Providers meet required qualifications.
4. Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).
5. The SMA retains authority and responsibility for program operations and oversight.
6. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.
7. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

| ***Requirement*** | **5. The SMA retains authority and responsibility for program operations and oversight.** |
|---|---|
| ***Discovery*** | |
| **Discovery Evidence** *(Performance Measure)* | Number and percent of issues identified in contract monitoring reports that were remediated as required by the state.<br><br>N = Number of issues identified in contract monitoring reports that were remediated as required by the State.<br><br>D = Total number of issues identified. |
| **Discovery Activity** *(Source of Data & sample size)* | Provider application. Less than 100% Review. The State will obtain a sample size that will produce a probability of 95% and confidence level of 5% using Raosoft Sample Size Calculator. |
| **Monitoring Responsibilities** *(Agency or entity that conducts discovery activities)* | SMA 1915(i) Unit. |
| **Frequency** | Annually |
| ***Remediation*** | |
| **Remediation Responsibilities** *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)* | SMA will remediate any issue or non-compliance within 30 days.<br><br>On a monthly basis, HCC supervisor reviews random sample of case files and if deficiencies are found, will take action as needed such as one-on-one education with the HCC as well as remediation discussion during the monthly QI meeting. |
| **Frequency** *(of Analysis and Aggregation)* | 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**<br>*(Performance Measure)* | Number and percent of claims paid to 1915(i) service providers who are qualified to furnish 1915(i) services to 1915(i) recipients.<br>N: Number of claims paid to 1915(i) service providers who are qualified to furnish 1915(i) services to 1915(i) recipients.<br>D: Number of claims reviewed. |
| **Discovery Activity**<br>*(Source of Data & sample size)* | Financial records (including expenditures); Less than 100% Review. The State will obtain a sample size that will produce a probability of 95% and confidence level of 5% using Raosoft Sample Size Calculator. |
| **Monitoring Responsibilities**<br>*(Agency or entity that conducts discovery activities)* | SMA QA |
| **Frequency** | Annually |
| ***Remediation*** | |
| **Remediation Responsibilities**<br>*(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)* | SMA will remediate any issue or non-compliance within 30 days.<br><br>Deficiencies are remediated through the monthly quality improvement (QI) meeting. The QI team consists of SMA QA and 1915(i) units. |
| **Frequency**<br>*(of Analysis and Aggregation)* | Monthly, Quarterly, Annually |

| ***Discovery*** | |
|---|---|
| **Discovery Evidence**<br>*(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.<br><br>N: Number of claims verified through a review of provider documentation that have been paid in accordance with the individual's service plan.<br>D: Total number of claims reviewed. |

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

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

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

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

| | | |
|---|---|---|
| | **Remediation Responsibilities**<br>*(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)* | SMA will remediate any issue or non-compliance within 30 days.<br>All Serious Occurrence Reports (SOR) must be reported within 24 hours of discovery. All SORs are entered into the database called Harmony, including follow-ups by HCCs. On a weekly basis or as needed, HCC supervisor reviews and approves follow-ups to ensure appropriate action is taken and the health and safety of the recipients have been addressed timely. Reports are generated upon request.<br>Within 5 business days, HCC will conduct all necessary follow-ups to include plan of correction, report submitted to law enforcement, EPS or Health Care Quality and Compliance (HCQC) if applicable.<br>The Harmony database monitors and tracks all incidents and generates reports upon request. The 1915(i) Supervisor will review SORs on a weekly or as needed basis. |
| | **Frequency**<br>*(of Analysis and Aggregation)* | Monthly, Quarterly, Annually |

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

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

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

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

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

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

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

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

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

2. **Roles and Responsibilities**

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

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

3. **Frequency**

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

**4. Method for Evaluating Effectiveness of System Changes**

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

# Methods and Standards for Establishing Payment Rates[AJ24]

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 | |
| | | |
| ☑ [CP25 | HCBS Habilitation | |
| | ~~**Prevocational Services –**~~<br>~~**Supported Employment –**~~ | |
| ☑ [CP26 | HCBS Respite Care | |
| | ~~**Planned Respite –**~~<br>~~**Crisis Respite –**~~ | |
| 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 -** | |
| | ~~**Family Supports Service –**~~ | |
| | ~~**Non-Medical Transportation –**~~ | |

## Groups Covered

Optional Groups other than the Medically Needy

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

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

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

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

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

☐ OTHER (*describe*):

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

☐ 300% of the SSI/FBR

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

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

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

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

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 114 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.