MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

January 26, 2021

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: JESSICA KEMMERER, HIPAA PRIVACY AND CIVIL RIGHTS OFFICER

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 4000 – 1915(i) HCBS STATE PLAN OPTION INTENSIVE IN-HOME SERVICES AND CRISIS STABILIZATION

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 4000 – 1915(i) Home and Community Based Services State Plan Option Intensive In-Home Services and Crisis Stabilization are being proposed being proposed to include an additional care coordination model, Safety Assessment Family Evaluation (SAFE), to be utilized by the local county agencies when evaluating individuals to be eligible for these services.

Throughout the chapter, grammar, punctuation and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

Entities Financially Affected: This proposed change affects all Medicaid-enrolled providers delivering Intensive In-Home Supports and Services and Crisis Stabilization Services. Those provider types include but are not limited to Specialized Foster Care Services – Provider Type 86.

Financial Impact on Local Government: The financial impact on local government is unknown at this time.

These changes are effective January 27, 2021.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL OL 1915(i) HCBS STATE PLAN OPTION INTENSIVE IN-HOME SERVICES AND CRISIS STABILIZATION	01/21 1915(i) HCBS STATE PLAN OPTION INTENSIVE IN-HOME SERVICES AND CRISIS STABILIZATION

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
4003.1A	**NEEDS BASED ELIGIBILITY CRITERIA**	Replace Case Manager/Wraparound Facilitator with Care Coordinator
4003.3F(1)(d)	**DOCUMENTATION STANDARDS**	Moved to d. from e.
4003.3F(1)(e)		Added additional care coordination model, SAFE
4003.3F(1)(f)		Added additional clarifying language to define Care Coordinator
4003.3F(1)(g)		Moved to g. from d.
4003.3F(1)(h)		Replace CM and WF with Care Coordinator
4003.3F(2)(a)	**PERSON CENTERED PLAN OF CARE**	Replace CM/WF with Care Coordinator
4003.3F(2)(d)		Replace CM/WF with Care Coordinator
4003.3G(1)	**RECIPIENT RESPONSIBILITIES**	Replace CM/WF with Care Coordinator
4003.3G(2)		Replace CM/WF with Care Coordinator
4003.3G(4)		Replace CM/WF with Care Coordinator
4003.3G(5)		Replace CM/WF with Care Coordinator
4003.3G(7)		Replace CM/WF with Care Coordinator

4003 POLICY

4003.1 NEEDS BASED ELIGIBILITY CRITERIA

The DHCFP 1915(i) Home and Community-Based Services (HCBS) State Plan Option utilizes a needs-based criteria to evaluate and reevaluate whether an individual is eligible for services. The criteria considers the individual's support needs and risk factors.

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

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

B. 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 Division of Child and Family Services (DCFS) or its designee as evidenced by at least one of the following risk factors:

1. At risk of higher level of care placement due to recent placement disruption within the past six months;

2. Current placement in emergency shelter or congregate care due to behavioral and mental health needs;

3. In need of transition to community-based living arrangement with intensive behavioral supports when returning or stepping down from residential treatment center or other higher level of care placement; and/or

C. HIPAA, PRIVACY, AND CONFIDENTIALITY

Refer to MSM Chapter 100 for information on HIPAA, privacy and confidentiality of recipient records, and other Protected Health Information (PHI).

D. NOTIFICATION OF SUSPECTED ABUSE OR NEGLECT

State law requires that persons employed in certain capacities must make a report to the appropriate agency immediately, but in no event later than 24 hours after there is reason to suspect abuse or neglect. The DHCFP expects that all providers be in compliance with the intent of all applicable laws.

E. SERIOUS OCCURRENCE REPORT (SOR)

Child welfare jurisdictions and agencies shall adhere to the requirements of NAC 424.476 in reporting any serious incident, accident, or injury to a child involving a foster home, or a child in a foster home to the licensing authority and any caseworker assigned to the child. Jurisdictions/agencies should refer to NAC 424.476 in determining specific incidents, accidents, and injuries that must be reported.

F. DOCUMENTATION STANDARDS

1. Assessment

a. 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.

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

c. The person-centered plan of care 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.

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

~~d. The Case Managers (CM)/Wraparound Facilitators (WF) must be independent of the Specialized Foster Care Agency.~~

e. All Case Workers (CW) will be trained in the Safety Assessment Family Evaluation (SAFE) model by local county agencies ~~All WF will be required to be certified by DCFS as a Wraparound Facilitator utilizing the standards of the National Wraparound Implementation Center. All CM will be required to be trained by DCFS in the FOCUS model utilizing the standards of the National Wraparound Implementation Center.~~

~~e.~~f. The term Care Coordinator will be used to encompass either the Child Welfare agency Case Worker or DCFS Care Manager/Wraparound Facilitator.

~~f.~~g. The Care Coordinators must be independent of the Specialized Foster Care Agency.

h. All Care Coordinators will be required to maintain appropriate certifications including certification on the Nevada Child and Adolescent Needs and Strengths tool (NV-CANS). Recipients will receive services of CW, CM, or WF based on level of need

~~g. All CM and WF will be required to maintain appropriate certifications including certification on the Nevada Child and Adolescent Needs and Strengths tool (NV-CANS). Recipients will receive either services of CM or WF based on level of need.~~

2. Person-centered Plan of Care (POC)

a. The development of the person-centered POC 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 Coordinator~~CM/WF~~, child or youth, caregiver(s), support

persons identified by the family (paid and unpaid), and service providers, including the youth's treating clinician as available.

b. 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.

c. The Care Coordinator ~~CM/WF~~ will utilize assessments to create the person-centered POC for children and families. The plan will include needs, outcomes, and strategies that are:

1. Specific. The CFT, including the family should know exactly what must be completed or changed and why.

2. Measurable. 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.

3. Achievable. The CFT and family should be able to meet the identified needs in a designated time period given the resources that are accessible and available to support change.

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

3. Progress Notes: Progress notes for all Behavioral Health services including Rehabilitative Mental Health (RMH) and Outpatient Mental Health services are the written documentation of treatment services, or service coordination provided to the recipient pursuant to the Treatment Plan, which describes the progress, or lack of progress towards the goals and objectives of the Treatment Plan.

a. All progress notes documented with the intent of submitting a billable Medicaid behavioral health service claim must be documented in a manner that is sufficient to support the claim and billing of the services provided and must further document the amount, scope, and duration of the service(s) provided as well as identify the provider of the service(s).

b. A Progress Note is required for each day the service was delivered, must be legible and must include the following information:

1. The name of the individual receiving the service(s). If the services are in a group setting, it must be indicated;

2. The place of service;

3. The date the service was delivered;

4. The actual beginning and ending times the service was delivered;

5. The name of the provider who delivered the service;

6. The credentials of the person who delivered the service;

7. The signature of the provider who delivered the service;

8. The goals and objectives that were discussed and provided during the time the services were provided; and

9. A statement assessing the recipient's progress towards attaining the identified treatment goals and objectives requested by the treatment team.

c. Temporary, but clinically necessary, services do not require an alteration of the treatment plan; however, these types of services, and why they are required, must be identified in a progress note. The note must follow all requirements for progress notes as stated within this section.

G. RECIPIENT RESPONSIBILITIES

Individuals receiving 1915(i) services are entitled to their privacy, to be treated with respect and be free from coercion and restraint.

The recipient or the custodian of the child will:

1. Notify the provider(s) and Care Coordinator ~~CM/WF~~ of a change in Medicaid eligibility.

2. Notify the provider(s) and Care Coordinator ~~CM/WF~~ of changes in medical status, service needs, or changes of status of designated representative.

3. Initial and/or sign the provider service documentation logs as applicable, verifying services were rendered unless otherwise unable to perform this task due to cognitive and/or physical limitations.

4. Notify the Care Coordinator ~~CM/WF~~ if services are no longer requested or required.

5. Notify the provider(s) and the Care Coordinator ~~CM/WF~~ of unusual occurrences, complaints regarding delivery of services or specific staff.

6. Not request a provider(s) to perform services not authorized in the plan of care.

7. Contact the Care Coordinator ~~CM/WF~~ to request a change of provider.

4003.4 INTENSIVE IN-HOME SERVICES

4003.4A COVERAGE AND LIMITATIONS

A. 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