

MEDICAID OPERATIONS MANUAL
TRANSMITTAL LETTER

December 10, 2015

TO: CUSTODIANS OF MEDICAID OPERATIONS MANUAL

FROM: TAMMY MOFFITT, CHIEF OF PROGRAM INTEGRITY

SUBJECT: MEDICAID OPERATIONS MANUAL CHANGES
CHAPTER 600 – KATIE BECKETT ELIGIBILITY OPTION

BACKGROUND AND EXPLANATION

Revisions to MOM Chapter 600 – Katie Beckett Eligibility Option are being proposed to change all references to Mentally Retarded and Intermediate Facility for the Mentally Retarded (ICF/MR) to Individuals with Intellectual Disabilities and Intermediate Facility for Individuals with Intellectual Disabilities (ICF/IID) which is the currently acceptable terminology. Included in this revision is the Division of Health Care Financing and Policy (DHCFP) in the initiation of Notice of Decisions (NOD).

These changes are effective December 11, 2015.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
CL 29450 CHAPTER 600 - KATIE BECKETT ELIGIBILITY OPTION	MTL 21/12, 05/14 CHAPTER 600 - KATIE BECKETT ELIGIBILITY OPTION

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
600	Introduction	Removed language "ICF/MR" and added "ICF/IID", Removed language "the Mentally Retarded" and added "Individuals with Intellectual Disabilities". Removed language "by their nature".
602	Definitions - Capable	Removed language "health/medical care".
	Definitions - Diary or Diary Date	Added to definition for clarity. "Diary dates are determined by the physician consultant based on Medical Improvement Possible (MIP) or Medical Improvement Not Expected (MINE)".
	Definitions - Functional Ability	Definition reworded for clarity.

	Definitions - Functional Impairment	Definition reworded for clarity.
	Definitions - Health Education	Removed Definition.
	Definitions - Intermediate Care Facility for the Mentally Retarded	Removed language "the Mentally Retarded (MR)" and added Individuals with Intellectual Disabilities (IID)".
	Definitions - Intermediate Care Services for the Mentally Retarded	Removed "the Mentally Retarded" and added "Individuals with Intellectual Disabilities".
	Definitions - Level of Care (LOC) Assessment	Removed language "ICF/MR" and added "ICF/IID".
	Definitions - Notice of Decision	Added language "or the DHCFP".
603.1.b	General Eligibility Criteria	Removed language "Mentally Retarded (MR)" and added "Individuals with Intellectual Disabilities (IID)".
603.1.e		Added language "as DWSS determines financial eligibility".
603.2	Eligibility Determination	Remove language "Division of Mental Health and Developmental Services (MHDS)" and added "Aging and Disability Services Division (ADSD)".
603.2.b.3	Eligibility Determination	Removed language "mental retardation" and added "intellectual disability". Removed reference to "MHDS" and added "ADSD".
603.2.c	Eligibility Determination	Removed language "MHDS" and added "ADSD". Removed language "mental retardation" and added Intellectual Disability".
603.2.c.1	Eligibility Determination	Removed language "ICF/MR" and added "ICF/IID". Removed language "Mental Retardation Professional (QMRP)" and added "Intellectual Disability Professional (QIDP)".

603.5	Level of Care (LOC)	Removed language "MR" and added "IID".
603.5.c	Level of Care (LOC)	Removed language "Mentally Retarded (MR)" and added "Individuals with Intellectual Disabilities (IID)". Removed "MHDS" and added "ADSD".
603.6.A	Rate Methodology and Cost Effectiveness	Added language "for the appropriate LOC". Removed language "ICF/MR" and added "ICF/IID".
603.6.B	Rate Methodology and Cost Effectiveness	Removed language "ICF/MR" and added "ICF/IID".
603.6.C	Rate Methodology and Cost Effectiveness	Removed language "DWSS" and added "DHCFP". Removed language "by the DHCFP staff".
605	References and Cross References	Removed language "Mentally Retarded" and added "Individuals with Intellectual Disabilities".

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DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 600
MEDICAID OPERATIONS MANUAL	Subject: INTRODUCTION

600 INTRODUCTION

Under Section 134 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), States are allowed the option to make Medicaid benefits available to eligible children with disabilities who would not ordinarily qualify for Supplemental Security Income (SSI) benefits because of the parents' income or resources.

Section 134 is also known as the "Katie Beckett" Option in reference to the child whose disability prompted this change. Under the Katie Beckett Eligibility Option Medicaid eligibility category, a State is allowed to waive the deeming of parental income and resources for a disabled child under 19 years of age who would be eligible for Medicaid if he or she were in a medical institution and who is receiving, while living at home, medical care that would normally be provided in a medical institution.

The child must require a Level of Care (LOC) that would make him or her eligible for placement in a hospital, Nursing Facility (NF), or Intermediate Care Facility for ~~the Mentally Retarded Individuals with Intellectual Disabilities~~ (ICF/MRIID). A physician must sign a statement indicating that it is appropriate for the child to receive services in the home. These eligibility criteria are redetermined on an annual basis or in the case of a Pediatric Specialty Care level, every six (6) months.

For children who become eligible for Medicaid under the Katie Beckett Eligibility Option, Medicaid covers medically necessary services as defined by the Medicaid State Plan. Waiver services, ~~by their nature~~, are not available to children enrolled in the Katie Beckett Eligibility Option.

There is a monetary limit to the Medicaid medical coverage costs. The cost of the child's care in the home must be no greater than the amount Medicaid would pay if the child was institutionalized.

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602 DEFINITIONS

ABLE

An able parent and/or legal guardian of a minor child, is a Legally Responsible Individual (LRI) who has the option to be present in the home during the time of carrying out necessary maintenance, health/medical care, education, supervision, support services and/or the provision of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) as needed.

ACTIVITIES of DAILY LIVING (ADLs)

ADLs are self care activities routinely preformed on a daily basis, such as bathing, dressing, grooming, toileting, transferring, mobility continence and eating.

For the purpose of evaluation, the ADLs are defined as:

- Bathing/Dressing/Grooming: Includes bathing (washing oneself in a bathtub or shower, or by sponge bath. It also includes the individual’s ability to get into and out of the shower or tub), dressing and undressing and personal hygiene.
- Toileting: Includes getting to and from the toilet, getting on and off the toilet and performing associated personal hygiene. Also includes the routine maintenance of incontinence.
- Transferring: Includes moving into or out of a chair, bed or wheelchair.
- Mobility: Includes walking and getting around with the use of assistive devices or with assistance.
- Eating: Putting food into the body from a cup, plate, feeding tube or intravenously. Does not include the preparation of food which is an IADL.

AGE APPROPRIATE

A developmental concept whereby certain activities may be deemed appropriate or inappropriate to the child’s “stage” or level of development (developmental milestones).

CAPABLE

A capable parent and/or legal guardian of a minor child, is an LRI who is physically and cognitively capable of carrying out necessary maintenance, ~~health/medical care~~, education,

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supervision, support services and/or the provision of needed ADLs and IADLs.

CARE COORDINATION

A formal process that ensures ongoing coordination of efforts on behalf of Medicaid-eligible recipients who meet the care criteria for a higher intensity of needs. Care coordination includes: facilitating communication and enrollment between the recipient and providers and providing for continuity of care by creating linkages to and monitoring transitions between intensities of services. Care coordination is a required component of case management services and is not a separate reimbursable service.

COST EFFECTIVENESS

The method by which the Division of Health Care Financing and Policy (DHCFP) monitors and tracks reimbursement for medical services to ensure that the established Level of Care (LOC) cost limitations are not exceeded.

DEVELOPMENTAL MILESTONE

A functional ability that is achieved by most children at a certain age. Developmental milestones can include physical, social, emotional, cognitive and communication skills.

DIAGNOSIS

The determination of the nature or cause of physical or mental disease or abnormality through the combined use of health history, physical developmental examination, and laboratory tests.

DIARY or DIARY DATE

Specific to the Katie Beckett Eligibility Option, the diary date drives the physician consultant's disability reevaluation date. The disability reevaluation date can be established for one, two or three years from the initial disability determination date. **Diary dates are determined by the physician consultant based on Medical Improvement Possible (MIP) or Medical Improvement Not Expected (MINE).**

DISABILITY DETERMINATION

The DHCFP's physician consultant and professional staff make up the disability determination team. The team reviews medical documentation and determines if the applicant qualifies based on Social Security Disability Standards. Those standards outlined by Social Security Disability are:

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- a. The child/participant must have a physical or mental condition(s) that seriously limits his or her life activities; and
- b. The condition(s) must have lasted, or be expected to last, at least one year or the condition is expected to be terminal.

ELIGIBILITY

References a person's status to receive Medicaid program benefits. Eligibility is determined by the Division of Welfare and Supportive Services (DWSS) based upon specific criteria for the Katie Beckett Eligibility Option.

FUNCTIONAL ABILITY

Functional ability is defined as a measurement of the ability to perform ADLs and IADLs progressing from dependence to independence. This includes, but may not be limited to: ~~personal care, grooming, self feeding, transferring from bed to chair, ambulation or wheelchair mobility, functional use of extremities with or without the use of adaptive equipment, dressing, bathing, grooming, mobility, eating, meal preparation, shopping, cleaning,~~ effective speech or communication, ~~and~~ adequate functioning of the respiratory system for ventilation and gas exchange to supply the individual's usual activity level, and performing cognitive tasks such as problem solving, processing information and learning.

FUNCTIONAL IMPAIRMENT

Functional impairment is a temporary or permanent disability (resulting from an injury or sudden trauma, aging, disease or congenital condition) which limits a person's ability to perform one or more ADLs or IADLs including but not limited to: dressing, bathing, grooming, mobility, eating, meal preparation, shopping, cleaning, effective speech or communication, adequate functioning of the respiratory system for ventilation and gas exchange to supply the individuals usual activity level, and performing cognitive tasks such as problem solving, processing information and learning.

HEALTH EDUCATION

~~The guidance (including anticipatory) offered to assist in understanding what to expect in terms of a child's development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention.~~

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)

IADLs are activities related to independent living including preparing meals, shopping for groceries or personal items, performing light or heavy housework, communication and money management.

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INTERMEDIATE CARE FACILITY FOR ~~THE MENTALLY RETARDED INDIVIDUALS WITH INTELLECTUAL DISABILITIES~~ (ICF/~~MR~~IID)

An institution (or distinct part of an institution) which is primarily used for the diagnosis, treatment, or ~~re~~habilitation for persons with ~~mental retardation~~ ~~an intellectual disability~~ or a related condition. In a protected residential setting, an ~~ICF/MR-ICF/IID~~ facility provides ongoing evaluation, planning, 24-hour supervision, coordination, and integration for health and ~~re~~habilitative services to help individuals function if or when they are able to return home.

INTERMEDIATE CARE SERVICES FOR ~~THE MENTALLY RETARDED INDIVIDUALS WITH INTELLECTUAL DISABILITIES~~

Health and ~~re~~habilitative services provided to an ~~mentally retarded individual with intellectual disabilities~~ person or person with a related condition. The services are certified as needed and provided in a licensed inpatient facility.

LEGALLY RESPONSIBLE INDIVIDUAL (LRI)

Individuals who are legally responsible to provide medical support including: spouses of recipients, legal guardians, and parents of minor recipients, including: stepparents, foster parents and adoptive parents.

LEVEL OF CARE (LOC) ASSESSMENT

A screening assessment to determine if an applicant's or participant's condition requires the level of services provided in a hospital, Nursing Facility (NF), or ICF/~~MR~~IID.

NOTICE OF DECISION (NOD)

The method by which the DWSS ~~or the DHCFP~~ advises the participant of his or her Medicaid eligibility status.

PARENT

- a. natural, adoptive, or foster parent of a child (unless a foster parent is prohibited by State Law from serving as a parent);
- b. a guardian, but not the State if a child is a ward of the State;
- c. an individual acting in the place of a natural or adoptive parent (including a grandparent, stepparent or other relative) with whom the child lives; or
- d. an individual who is legally responsible for the child's welfare.

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MEDICAID OPERATIONS MANUAL	Subject: POLICY

603 POLICY

603.1 GENERAL ELIGIBILITY CRITERIA

Eligibility for Nevada Medicaid under Katie Beckett Eligibility Option allows the State to waive the deeming of parental income and resources for children who meet all of the following conditions:

- a. The child must be under 19 years of age and determined to be disabled based upon Social Security Disability Standards.
- b. The child must require a Level of Care (LOC) that would make him or her eligible for placement in a hospital, Nursing Facility (NF) or Intermediate Care Facility for ~~the Mentally Retarded Individuals with Intellectual Disabilities~~ (ICF/MRIID).
- c. A physician must sign a statement indicating that it is safe and appropriate for the child to receive care in the home.
- d. Expenditures must not exceed the amount that the Division of Health Care Financing and Policy (DHCFP) would pay for Medicaid services if the child was institutionalized.
- e. As an individual, the child's income and or resources do not exceed the limits established by the Division of Welfare and Supportive Services (DWSS). Income and resource limits can be obtained from the DWSS **as DWSS determines financial eligibility.**

603.2 ELIGIBILITY DETERMINATION

Applicants or participants must meet and maintain all eligibility criteria to remain on Medicaid under the Katie Beckett Eligibility Option. Eligibility determination is made on an annual basis by the combined efforts of the DWSS, the DHCFP and the ~~Division of Mental Health and Developmental Services (MHDS)~~ **Aging and Disability Services Division (ADSD)** when indicated.

- a. The DWSS processes applications to determine Medicaid eligibility.
 1. Parental income and resources are waived when determining the child's eligibility.
 2. The DWSS evaluates parental income and resources to establish the dollar amount of the Parental Financial Responsibility (PFR), if any.
 3. Collection of the PFR is the responsibility of the DWSS.

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- b. The DHCFP staff in the District Offices facilitate the processing of Katie Beckett Eligibility Option applications for Medicaid eligibility. Upon receipt of applicant information from the DWSS, the DHCFP District Office staff:
1. Complete a face-to-face interview and conduct a formal assessment of the child in the home setting to determine if an LOC exists.
 2. Facilitate the collection of medical records to forward to the DHCFP's Physician Consultant and review team at the DHCFP Central Office for disability determination and redeterminations.
 3. If a child does not meet a NF LOC, but medical records provide information indicating there is either an ~~an-mental-retardation~~ **intellectual disability** or related condition diagnosis, the parent(s) or guardian(s) is referred to **MHDSADSD** for further assessment.
- c. The ~~MHDS-ADSD~~ staff are responsible for the evaluation and determination of an ICF/~~MRIID~~ LOC for ~~mental-retardation-an~~ **intellectual disability** or related conditions.
1. The DHCFP requires that the individual determining an ICF/~~MRIID~~ LOC must be at least a Developmental Specialist III (DSIII) or a Qualified ~~Mental-Retardation~~ **Intellectual Disability** Professional (~~QMRPQIDP~~).
- d. Third Party Liability (TPL)
1. Refer to Medicaid Services Manual (MSM) Chapter 100.
 2. Participants eligible for Medicaid are required to pursue and/or maintain other health coverage if it is available at no cost to the recipient, parent, and/or legal guardian.

603.3 COVERAGE AND LIMITATIONS

Parental Responsibility

An able and/or capable parent or Legally Responsible Individual (LRI) of a minor child has a duty/obligation to provide the necessary maintenance, health/medical care, education, supervision and support. Necessary maintenance includes but not limited to, the provision of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). Payment will not be made for the routine care, supervision or services normally provided for the child without charge as a matter of course in the usual relationship among members of a family.

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603.4 CARE COORDINATION

Care Coordination is a component of the services provided by the District Office staff in the Long Term Support Services Unit which assists the participant to remain in his or her home. The role of the Katie Beckett Eligibility Option Health Care Coordinator is to:

- a. facilitate access to medical, social, educational, and other needed services regardless of the funding source.
- b. monitor quarterly calendar costs incurred to ensure that expenditures are not exceeded for the allowable cost limits and assist the family in prioritizing services.
- c. prepare parent or guardian for transition to other services when Medicaid eligibility is no longer met under the Katie Beckett Eligibility Option (i.e. SSI eligibility, age 19) and or assist with any ongoing or unmet needs.
 1. Coordinate with the DWSS caseworker to change eligibility category;
 2. Refer to Medicaid Waiver programs as appropriate; and
 3. Refer to community resources.
- d. make at least quarterly contact with parent or guardian by phone, letter or in person to ensure that all necessary services are accessed and identify any significant change in the child's condition or unmet needs, making referrals as necessary.
- e. conduct in-home visits with the child and parent or guardian for determination of a LOC, making appropriate referrals as necessary. The number of visits per year is driven by the LOC, but home visits are conducted at least annually.

603.5 LEVEL OF CARE (LOC)

LOC assessments must be age appropriate and take into consideration the diagnoses, developmental milestones and functional abilities of the child. ADLs may be looked at as tasks but must be developmentally appropriate in relationship to the child's age and that a child should be able to perform independently.

An NF or ICF/**MRIID** LOC is assigned for a one-year period of time after the initial assessment and evaluation. There is a home visit conducted at least annually to reassess the LOC.

NF Pediatric Specialty Care I and Pediatric Specialty Care II (Mechanical Ventilator Dependent) LOC's are assigned for a six month period, and a reassessment of the LOC occurs every six months.

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Service levels determine the monthly cost allowance available for services and supplies for the child.

- a. Nursing Facility Standard is appropriate when the child requires skilled nursing care or comprehensive rehabilitative interventions throughout the day which may include:
 1. The child's diagnoses require specialized professional training and monitoring beyond those normally expected of parents.
 2. The child requires skilled observation and assessment several times daily due to significant health needs.
 3. The child has unstable health, functional limitations, complicating conditions, cognitive or behavioral conditions, or is medically fragile such that there is a need for active care management.
 4. The child's impairment substantially interferes with the ability to engage in everyday activities and perform age appropriate activities of daily living at home and in the community, including but not limited to bathing, dressing, toileting, feeding, and walking/mobility.
 5. The child's daily routine is substantially altered by the need to complete these specialized, complex and time consuming treatments and medical interventions or self-care activities.
 6. The child needs complex care management and/or hands on care that substantially exceeds age appropriate assistance.
 7. The child needs restorative and rehabilitative or other special treatment.
- b. Nursing Facility Pediatric Specialty Care I and Pediatric Specialty Care II (Mechanical Ventilator Dependent). Limited to participants from birth to 19 years of age, who are medically fragile and require specialized, intensive, licensed skilled nursing care beyond the scope of services than what is generally provided to the majority of NF participants.

To qualify for this LOC, a participant must be receiving highly skilled services which require special training and oversight. Pediatric Specialty Care rates are approved for a maximum of six months at a time. Each Pediatric Specialty Care I or II child's LOC must be reevaluated every six months.

- c. Intermediate Care Facility for ~~the Mentally Retarded~~ Individuals with Intellectual Disabilities (ICF/MRIID). ~~MHDSADSD~~ determines the ICF/MRIID LOC.

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603.6 RATE METHODOLOGY AND COST EFFECTIVENESS

- A. The DHCFP uses the average daily NF rates **for the appropriate LOC** established by the DHCFP Rates & Cost Containment Unit. Rates for ICF/~~MRIID~~ are also established by the DHCFP Rates and Cost Containment Unit.
- B. The rates for the ICF/~~MRIID~~ facilities are averaged. This amount is then used when determining the allowable ICF/~~MRIID~~ rate for each participant who meets an ICF/~~MRIID~~ LOC.
- C. At the end of each calendar quarter, a list of approved Katie Beckett Eligibility Option cases is generated by the DHCFP staff. The list shows the total Medicaid expenditure amount incurred for that quarter for each eligible child under the Katie Beckett Eligibility Option.

The purpose is to ensure that the costs incurred by Medicaid for each child does not exceed the projected costs of institutional care. There are services and supplies that are not included in the Facility Rate and are excluded from the child's Institutional LOC overall costs.

If the adjusted incurred amount exceeds the maximum allowable amount, the eligibility worker at the appropriate ~~DWSS DHCFP~~ office is notified ~~by the DHCFP staff~~. The ~~DWSS DHCFP~~ staff will contact the participant's parent or legal guardian and advise him/her:

- 1. of the requirement to keep costs at or below the maximum allowable amount; and
- 2. that failure to keep costs at or below the maximum allowable amount for a second consecutive quarter will result in termination of Medicaid eligibility under the Katie Beckett Eligibility Option.

If the participant's incurred costs exceed the maximum allowable amount for two consecutive quarters, he/she will be terminated from the Katie Beckett Eligibility Option and consequently from Medicaid services, effective the first day of the month following the date of determination of non-compliance with program requirements.

An exception to this requirement occurs when a participant is re-evaluated by the DHCFP and determined to require a higher LOC (thereby increasing the maximum allowable amount).

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MEDICAID OPERATIONS MANUAL	Subject: REFERENCES AND CROSS REFERENCES

605 REFERENCES AND CROSS REFERENCES

Please consult chapters of the Medicaid Services Manual (MSM) which may correlate with this chapter.

Chapter 100	Medicaid Program
Chapter 200	Hospital Services
Chapter 300	Radiology Services
Chapter 400	Mental Health and Alcohol/Substance Abuse Services
Chapter 500	Nursing Facilities
Chapter 600	Physician Services
Chapter 700	Rates and Cost Containment
Chapter 800	Laboratory Services
Chapter 900	Private Duty Nursing
Chapter 1000	Dental Services
Chapter 1100	Ocular Services
Chapter 1200	Prescribed Drugs
Chapter 1300	DME, Disposable Supplies and Supplements
Chapter 1400	Home Health Agency
Chapter 1500	Healthy Kids Program (EPSDT)
Chapter 1600	Intermediate Care for the Mentally Retarded Individuals with Intellectual Disabilities
Chapter 1700	Therapy
Chapter 1900	Transportation Services
Chapter 2800	School Based Child Health Services
Chapter 3100	Hearings
Chapter 3300	Program Integrity
Chapter 3500	Personal Care Services (PCS) Program
Chapter 3600	Managed Care Organization

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

December 10, 2015

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: TAMMY MOFFITT, CHIEF OF PROGRAM INTEGRITY

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 400 – MENTAL HEALTH AND ALCOHOL/SUBSTANCE
ABUSE SERVICES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 400 are being proposed to strengthen policy throughout the chapter, to ensure System of Care philosophy. Proposed revisions include adding verbiage to direct providers to appropriate chapter for Applied Behavior Analysis (ABA) services and;

Additional proposed revisions include further clarification language to promote the importance of the System of Care core philosophy and approach of family driven, community based and culturally and linguistically competent services, ensuring that recipients will receive individualized comprehensive health services that promote collaboration between providers, utilize evidence-based practices, and continue to be family driven community-based services.

Clarification that Rehabilitative Mental Health (RMH) services cannot be billed the same day as Applied Behavior Analysis (ABA) services and direct providers to the appropriate MSM Chapter.

These changes are effective January 1, 2016.

MATERIAL TRANSMITTED

CL 29498
CHAPTER 400 - MENTAL HEALTH
AND ALCOHOL/SUBSTANCE ABUSE
SERVICES

MATERIAL SUPERSEDED

MTL 21/15
CHAPTER 400 – MENTAL HEALTH
AND ALCOHOL/SUBSTANCE ABUSE
SERVICES

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
400	Introduction	Added clarification to include definition of instruction concerning System of Care.
403.6B	Rehabilitative Mental Health (RMH) Services	Added clarification to include definition of instruction concerning ABA Services.

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DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 400
MEDICAID SERVICES MANUAL	Subject: INTRODUCTION

MENTAL HEALTH AND ALCOHOL/SUBSTANCE ABUSE SERVICES

400 INTRODUCTION

Nevada Medicaid reimburses for community-based and inpatient mental health services to both children and adults under a combination of mental health rehabilitation, medical/clinical and institutional authority. The services must be recommended by a physician or other licensed practitioner of the healing arts, within their scope of practice under State law for the maximum reduction of a physical or mental disability and to restore the individual to the best possible functioning level. The services are to be provided in the least restrictive, most normative setting possible and may be delivered in a medical professional clinic/office, within a community environment, while in transit and/or in the recipient's home. All services must be documented as medically necessary and appropriate and must be prescribed on an individualized Treatment Plan.

Mental health rehabilitation assists individuals to develop, enhance and/or retain psychiatric stability, social integration skills, personal adjustment and/or independent living competencies in order to experience success and satisfaction in environments of their choice and to function as independently as possible. Interventions occur concurrently with clinical treatment and begin as soon as clinically possible.

Alcohol and substance abuse treatment and services are aimed to achieve the mental and physical restoration of alcohol and drug abusers. To be Medicaid reimbursable, while services may be delivered in inpatient or outpatient settings (inpatient substance abuse hospital, general hospital with a substance abuse unit, mental health clinic, or by an individual psychiatrist or psychologist), they must constitute a medical-model service delivery system.

All Medicaid policies and requirements (such as prior authorization, etc.) except for those listed in the Nevada Check Up (NCU) Chapter 1000, are the same for NCU. Chapter 400 specifically covers behavioral health services and for other Medicaid services coverage, limitations and provider responsibilities, the specific Medicaid Services Manual (MSM) needs to be referenced.

Nevada Medicaid's philosophy assumes that behavioral health services shall be person-centered and/or family driven. All services shall be culturally competent, community supportive, and strength based. The services shall address multiple domains, be in the least restrictive environment, and involve family members, caregivers and informal supports when considered appropriate per the recipient or legal guardian. Service providers shall collaborate and facilitate full participation from team members including the individual and their family to address the quality and progress of the individualized care plan and tailor services to meet the recipient's needs. In the case of child recipients, providers shall deliver youth guided effective/comprehensive, evidence-based treatments and interventions, monitor child/family outcomes through utilization of Child & Family Team meetings, and continuously work to improve services in order to ensure overall fidelity of recipient care. (Reference Addendum – Medicaid Services Manual (MSM) Definitions).

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initially and annually thereafter. Testing and surveillance shall be followed as outlined in NAC 441A.375.3.

f. The purpose of the annual training is to facilitate the development of specialized skills or knowledge not included in the basic training and /or to review or expand skills or knowledge included in the basic training. Consideration must be given to topics suggested by recipients. Documentation of the completed training and achieved competencies meeting this requirement must be maintained by the BHCN or Independent RMH provider. Training requirements may be waived if the QBA can provide written verification of comparable education and training. The BHCN or Independent RMH provider must document the comparability of the written verification to the QBA training requirements.

2. QMHA, refer to Section 403.3A.

3. QMHP, refer to Section 403.3B.

403.6B

REHABILITATIVE MENTAL HEALTH (RMH) SERVICES

1. Scope of Service: RMH services must be recommended by a QMHP within the scope of their practice under state law. RMH services are goal oriented outpatient interventions that target the maximum reduction of mental and/or behavioral health impairments and strive to restore the recipient's to their best possible mental and/or behavioral health functioning. RMH services must be coordinated in a manner that is in the best interest of the recipient. RMH services may be provided in a variety of community and/or professional settings. The objective is to reduce the duration and scope of care to the least intrusive level of mental and/or behavioral health care possible while sustaining the recipient's overall health. All RMH services must be directly and medically necessary. **RMH services cannot be reimbursed on the same day as Applied Behavior Analysis (ABA) services, refer to Medicaid Services Manual (MSM) Chapter 1500.**

Prior to providing RMH services, a QMHP must conduct a comprehensive assessment of an individual's rehabilitation needs including the presence of a functional impairment in daily living and a mental and/or behavioral health diagnosis. This assessment must be based on accepted standards of practice and include a covered, current ICD diagnosis. The assessing QMHP must approve a written Rehabilitation Plan. The rehabilitation strategy, as documented in the Rehabilitation Plan, must be sufficient in the amount, duration and scope to achieve established rehabilitation goals and objectives. Simultaneously, RMH services cannot be duplicative (redundant) of each other. Providers must assure that the RMH services they provide are coordinated with other servicing providers. Case records must be maintained on recipients receiving RMH services. These case records must include and/or indicate:

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December 10, 2015

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: TAMMY MOFFITT, CHIEF OF PROGRAM INTEGRITY

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 3600 – MANAGED CARE ORGANIZATION

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 3600 are being proposed to incorporate the recent Centers for Medicare and Medicaid Services (CMS) approval that Managed Care Organizations (MCO) could provide services within an alternative inpatient setting, when the facility is licensed by the State of Nevada, and services within the facility are provided at a lower cost than that of services provided within a traditional inpatient hospital setting.

These changes are retroactively applied to align with revised covered services outlined within the managed care contract amendment number five.

These changes are effective November 3, 2014.

<u>MATERIAL TRANSMITTED</u>	<u>MATERIAL SUPERSEDED</u>
CL 29160 CHAPTER 3600 - MANAGED CARE ORGANIZATION	MTL 29/12, 10/13, 06/14 CHAPTER 3600 - MANAGED CARE ORGANIZATION

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3603.4.f	Excluded Services and/or Coverage Limitations-IMDs	Removed language "Mentally Retarded", "MR" and added "Individuals with Intellectual Disabilities", "IID".
3603.4.i	Inpatient Hospital Services	Removed language "Institutions for Mental Disease (IMD)" and added "Inpatient Hospital Services". Revised language to reflect updated inpatient hospital services rules including alternative inpatient settings by Nevada licensed facilities when costs of services are lower than traditional inpatient settings.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3603.15.A	Enrollment and Disenrollment Requirements and Limitations	Removed language "Situations" and added "A situation".
3603.15.A.6		Removed #6: "Enrollee enters an Institution for Mental Disease; or".

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3603.2 GEOGRAPHIC AREA

The State assures individuals will have a choice of at least two MCOs for the Medicaid Managed Care recipients in each geographic area. When fewer than two MCOs are available for choice in the geographic areas listed, the Managed Care Program will be voluntary.

3603.3 COVERED SERVICES

No enrolled recipient shall receive fewer services in the Managed Care Program than they would receive in the current Nevada State Plans, except as contracted or for excluded services noted in Section 3603.4 below.

Any new services added or deleted from the Medicaid benefit package will be analyzed for inclusion or exclusion in the MCO benefit package.

3603.4 EXCLUDED SERVICES AND/OR COVERAGE LIMITATIONS

The following services are either excluded as an MCO covered benefit or have coverage limitations. Exclusions and limitations are identified as follows:

a. All services provided at IHS Facilities and Tribal Clinics

AI/AN may access and receive covered medically necessary services at IHS facilities and Tribal Clinics. If an AI/AN voluntarily enrolls with an MCO and seeks covered services from IHS, the MCO should request and receive medical records regarding those covered services/treatments provided by IHS. If treatment is recommended by IHS and the enrollee seeks the recommended treatment through the MCO, the MCO must either provide the service or must document why the service is not medically necessary. The documentation may be reviewed by the Division of Health Care Financing and Policy (DHCFP) or other reviewers. The MCO is required to coordinate all services with IHS. If an AI/AN recipient elects to disenroll from the MCO, the disenrollment will commence no later than the first day of the next administratively possible month and the services will then be reimbursed by Fee-For-Service (FFS).

b. Non-emergency transportation

A contracted vendor will authorize and arrange for all medically necessary non-emergency transportation. The MCO must verify medical appointments upon request by the DHCFP or their designee.

c. All Nursing Facility stays over 45 days

The MCO is required to cover the first 45 days of a Nursing Facility admission, pursuant

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to the Medicaid Services Manual (MSM). The MCO is also required to collect any patient liability (pursuant to 42 Code of Federal Regulations (CFR) 435.725) for each month a capitated payment is received, pursuant to the MSM. The MCO shall notify the DHCFP by the 40th day of any nursing facility stay expected to exceed 45 days. The enrollee will be disenrolled from the MCO and the stay will be covered by FFS commencing on the 46th day of the facility stay.

d. Swing bed stays in acute hospitals over 45 days

The MCO is required to cover the first 45 days of a swing bed admission pursuant to the MSM. The MCO is also required to collect any patient liability (pursuant to 42 CFR 435.725) for each month a capitated payment is received, pursuant to the MSM. The MCO shall notify the DHCFP by the 40th day of any swing bed stay expected to exceed 45 days. The enrollee will be disenrolled from the MCO and the stay will be covered by FFS commencing on the 46th day of the facility stay.

e. School Based Child Health Services (SBCHS)

The DHCFP has an agreement with several school districts to provide selected medically necessary covered services through SBCHS to eligible Title XIX Medicaid and Title XXI Nevada Check Up (NCU) recipients.

Eligible Medicaid enrollees, who are three years of age and older, can be referred to an SBCHS for an evaluation by their private physician, school physician, special education teacher, school nurse, school counselor, parent or guardian, or social worker. If the child is found eligible for these services, then an Individual Education Plan (IEP) is developed for the child. The IEP specifies services needed for the child to meet educational goals. A copy of the IEP will be sent to the child's Primary Care Physician (PCP) within the managed health care plan, and maintained in the enrollee's medical record.

The school districts provide, through school district employees or contract personnel, the majority of specified medically necessary covered services. Medicaid reimburses the school districts for these services in accordance with the school district contract. The MCO will provide covered medically necessary services beyond those available through school districts, or document why the services are not medically necessary. The documentation may be reviewed by the DHCFP or its designees. Title XIX Medicaid and Title XXI NCU eligible children are not limited to receiving health services through the school districts. Services may be obtained through the MCO rather than the school district, if requested by the parent/legal guardian. The MCO case manager shall coordinate with the school district in obtaining any services which are not covered by the plan or the school district.

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- f. Intermediate Care Facility for ~~the Mentally Retarded~~ Individuals with Intellectual Disabilities (ICF/~~MR~~IID)

Residents of ICF/~~MR~~IID facilities are not eligible for enrollment with the MCO. If a recipient is admitted to an ICF/~~MR~~IID after MCO enrollment, the recipient will be disenrolled from the MCO and the admission, bed day rate, and ancillary services will be reimbursed through FFS.

- g. Residential Treatment Center (RTC) Limitations

It is the MCO's responsibility to provide reimbursement for all ancillary services (i.e., physician services, optometry, laboratory, dental and x-ray services, and similar services) for enrollees under the Title XXI, NCU, throughout their RTC admission. These enrollees will remain enrolled with the MCO throughout their RTC stay. The RTC bed day rate will be covered by FFS for NCU enrollees commencing the first day of admission.

Enrollees who are covered under Title XIX Medicaid will be disenrolled from the MCO the first day of the next administratively possible month following the RTC admission. It is the MCO's responsibility to provide reimbursement for all RTC charges including admission, bed day rate, and ancillary services until properly disenrolled from managed care. The RTC admission, bed day rate, and ancillary services will be reimbursed through FFS thereafter for Title XIX Medicaid recipients.

- h. Hospice

Recipients who are receiving Hospice Services are not eligible for enrollment with the MCO. Hospice Services are an optional program under the Social Security Act XVIII Section 1905(o)(1)(A) and are governed by 42 CFR 418 and 489.102(I). Once admitted into hospice care, Medicaid members will be disenrolled immediately. NCU recipients will not be disenrolled. However, payment for NCU hospice services will be billed as FFS. It is the responsibility of the MCOs to provide reimbursement for all ancillary services until properly disenrolled from managed care.

- i. ~~Institutions for Mental Diseases (IMDs)~~Inpatient Hospital Services

~~Federal regulations stipulate that Medicaid can only reimburse for services to IMD/psychiatric hospital patients who are 65 years of age or older or under the age of 21 years. Managed Care Organizations may provide inpatient hospital services, to mandatorily enrolled recipients within an alternative inpatient setting, which is licensed by the State of Nevada, in lieu of services in an inpatient hospital. The alternative inpatient setting must be a lower cost than the traditional inpatient setting. Residents of IMD facilities who are 21 years of age through 64 years of age are not eligible for~~

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~~enrollment with the MCO. If a recipient is admitted to an IMD after MCO enrollment, the recipient will be disenrolled.~~

j. Adult Day Health Care

Recipients who are receiving Adult Day Health Care (ADHC) (Provider Type 39) services are not eligible for enrollment with the MCO. ADHC Services are optional Medicaid State Plan services and authorized under State Plan authority titled “Nevada 1915(i) State Plan Home and Community-Based Services (HCBS)”. If a recipient is made eligible for ADHC after MCO enrollment, the recipient will be disenrolled and the ADHC will be reimbursed through FFS. It is the responsibility of the MCOs to provide reimbursement for all ancillary services until properly disenrolled from managed care.

k. Home and Community Based Waiver (HCBW) Services

Recipients who are receiving HCBW Services are not eligible for enrollment with the MCO. If a recipient is made eligible for HCBW Services after MCO enrollment, the recipient will be disenrolled and the HCBW Services will be reimbursed through FFS.

l. All Pre-Admission Screening and Resident Review (PASRR) and Level of Care (LOC) Assessments are performed by the State’s Fiscal Agent.

Conducting a PASRR and LOC will not prompt MCO disenrollment, however, if the recipient is admitted to a nursing facility as the result of a PASRR and LOC, the MCO is responsible for the first 45 days of admission (see #c above).

m. SED/SMI

The MCO must ensure enrollees who are referred for evaluation for SED/SMI or who have been determined SED/SMI by the health plan are obtaining the medically necessary evaluations by an in-network provider and that enrollees are transitioned, as necessary, to another provider in order to obtain their mental health services if such services are not available within the network. The MCO is required to notify the DHCFP if a Title XIX Medicaid recipient elects to disenroll from the MCO following the determination of SED/SMI and forward the enrollee’s medical records to the provider from whom the enrollee will receive the covered mental health services. However, in the event the Medicaid enrollee who has received such a determination chooses to remain enrolled with the MCO, the MCO will be responsible for providing all patient care.

The MCO is required to adhere to MSM Chapter 400 and 2500 for all SED and SMI referrals and determinations and must reimburse providers of these services pursuant to the referenced MSM Chapters. Such services include, but are not limited to: case management; lab work; prescription drugs; acute in-patient; and, other ancillary medical

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- i. Such other necessary health care, diagnostic services, treatment, and other measures described in Section 1905(a) of the Social Security Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State Medicaid Plan.

The MCO is not required to provide any items or services which are determined to be unsafe or ineffective, or which are considered experimental. Appropriate limits may be placed on EPSDT services based on medical necessity.

The MCO is required to provide information and perform outreach activities to eligible enrolled children for EPSDT services. These efforts may be reviewed and audited by the DHCFP or its designee.

3603.15 ENROLLMENT AND DISENROLLMENT REQUIREMENTS AND LIMITATIONS

A. Eligibility and Disenrollment

The eligibility and enrollment functions are the responsibility of the DHCFP and the Division of Welfare and Supportive Services (DWSS). The MCO shall accept each recipient who is enrolled in or assigned to the MCO by the DHCFP and/or its enrollment sections and/or for whom a capitation payment has been made or will be made by the DHCFP to the MCO. The first date a Medicaid or NCU eligible recipient will be enrolled is not earlier than the applicable date in the MCO's specified contract.

The MCO must accept recipients eligible for enrollment in the order in which they apply without restriction, up to the limits set under the contract. The MCO acknowledges that enrollment is mandatory except in the case of voluntary enrollment programs that meet the conditions set forth in 42 CFR 438.50(a). The MCO will not, on the basis of health status or need for health services, discriminate against recipients eligible to enroll. The MCO will not deny the enrollment nor discriminate against any Medicaid or NCU recipients eligible to enroll on the basis of race, color or national origin and will not use any policy or practice that has the effect of discrimination on the basis of race, color or national origin. If the recipient was previously disenrolled from the MCO as the result of a grievance filed by the MCO, the recipient will not be re-enrolled with the MCO unless the recipient wins an appeal of the disenrollment. The recipient may be enrolled with another MCO.

The State reserves the right to recover pro-rated capitation whenever the MCO's responsibility to pay medical claims ends in mid-month. ~~Situations~~A situation where a mid-month capitation recovery may occur includes, but is not limited to:

- 1. Enrollee is in a nursing facility over 45 days;

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2. Enrollee is in an acute hospital swing bed over 45 days;
3. Enrollee is placed in an out of home placement;
4. Medicaid enrollee is placed in a hospice;
5. Enrollees enters an ICF/MR; **or**
- ~~6. Enrollee enters an Institution for Mental Disease; or~~
- ~~7.6.~~ Enrollee enters an HCBW Program.

The MCO is not financially responsible for any services rendered during a period of retroactive eligibility except in the specific situation(s) described in this Chapter. The MCO is responsible for services rendered during a period of retroactive enrollment in situations where errors committed by the DHCFP or the DWSS, though corrected upon discovery, have caused an individual to not be properly and timely enrolled with the MCO. In such cases, the MCO shall only be obligated to pay for such services that would have been authorized by the MCO had the individual been enrolled at the time of such services. For in-state providers in these circumstances, the MCO shall pay the providers for such services only in the amounts that would have been paid to a contracted provider in the applicable specialty. Out-of-state providers in these circumstances will be paid according to a negotiated rate between the MCO and the out-of-state provider. The timeframe to make such corrections will be limited to 180 days from the incorrect enrollment date. The DHCFP is responsible for payment of applicable capitation for the retroactive coverage. As described in Section 3603.15 (B) (1) of the MSM, the Vendor is responsible for Medicaid newborns as of the date of birth, provided the mother was actively enrolled or retro-actively enrolled at the date of birth.

The MCO must notify a recipient that any change in status, including family size and residence, must be immediately reported by the recipient to the DWSS eligibility worker.

The MCO must provide the DHCFP with weekly electronic notification of all births and deaths.

B. Enrollment of Pregnant Women

The eligibility of Medicaid applicants is determined by the DWSS. DWSS notifies the state's fiscal agent who enrolls the applicant. Letters are sent to the new recipients requiring them to select an MCO or an MCO will be automatically assigned. The MCO will be notified of the pregnant woman's choice by the State's fiscal agent. The MCO shall be responsible for all covered medically necessary obstetrical services and pregnancy related care commencing on the date of enrollment.