

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):

<ol style="list-style-type: none"> 1. Intensive In-Home Services and Supports 2. Crisis Stabilization Services
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2. Concurrent Operation with Other Programs. (Indicate whether this benefit will operate concurrently with another Medicaid authority):

Select one:

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

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

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

<input type="radio"/>	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 <i>(select one)</i> :		
<input type="radio"/>	The Medical Assistance Unit <i>(name of unit)</i> :		
<input type="radio"/>	Another division/unit within the SMA that is separate from the Medical Assistance Unit		
	<i>(name of division/unit)</i> This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.		
<input checked="" type="radio"/>	The State plan HCBS benefit is operated by <i>(name of agency)</i>		
	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	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Eligibility evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Review of participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Prior authorization of State plan HCBS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Utilization management	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7. Execution of Medicaid provider agreement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. Establishment of a consistent rate methodology for each State plan HCBS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Rules, policies, procedures, and information development governing the State plan HCBS benefit	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

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

ACRONYM	ENTITY NAME	ENTITY TYPE	(SFC) 1915 (I) HCBS FUNCTION
SMA	State Medicaid Agency (AKA DHCFP)	State	Administering Agency
DHCFP	Division of Health Care Financing and Policy (AKA SMA)	State	Medicaid Agency
DCFS	Division of Child and Family Services	State	Operating Agency
FAC	Fiscal Agent Contractor (For SMA)	Private	Contracted Entity
CCDFS (DFS)	Clark County Department of Family Services	County	Local Non-State Entity
WCHSA (HSA)	Washoe County Human Services Agency	County	Local Non-State Entity
FUNCTION: #1 Individual State Plan HCBS Enrollment	Administering Agency (DHCFP/SMA) will provide oversight of DCFS, including their contracted entity, and Local Non-State Entities as they perform the Individual State Plan HCBS Enrollment.		
FUNCTION: #2 Eligibility Evaluation	Administering Agency (DHCFP/SMA) Performs Eligibility Evaluation Oversight of DCFS, including their contracted entity, and Local Non-State Entities.		
FUNCTION: #3 Participant Service Plan Reviews	Administering Agency (DHCFP/SMA) will provide oversight of DCFS, including their contracted entity, and Local Non-State Entities who review Participant's Service Plans.		
FUNCTION: #4 State Plan HCBS Prior Authorization	Administering Agency (DHCFP/SMA) or their Fiscal Agent Contractor (FAC) will be responsible for Prior Authorization (PA) activities.		
FUNCTION: #5 Utilization Management	Administering Agency (DHCFP/SMA) or their Fiscal Agent Contractor (FAC) will perform Utilization Management.		
FUNCTION: #6 Qualified Provider Enrollment	Administering Agency (DHCFP/SMA), Operating Agency and Local Non-State Entities are responsible for qualified provider enrollment.		
FUNCTION: #7 Medicaid Provider Agreement Execution	Administering Agency (DHCFP/SMA) and FAC are responsible for execution of Medicaid Provider Agreement.		
FUNCTION: #8	Administering Agency (DHCFP/SMA) is responsible for establishment of consistent rate methodology for each State Plan HCBS.		

State Plan HCBS Rate Methodology Establishment	
FUNCTION: #9 State Plan HCBS Rules/Policies/ Procedure/ Information Development	Administering Agency (DHCFP/SMA) and DCFS are responsible for developing rules, policies, procedures, and information governing each State Plan HCBS benefit.
FUNCTION: #10 Quality Assurance/ Improvement Activities	Administering Agency (DHCFP/SMA), DCFS, including their contracted entity, and Local Non-State Entities perform quality assurance and quality improvement activities.

0(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 ensures, at a minimum, that persons performing these functions are not:
 - related by blood or marriage to the individual, or any paid caregiver of the individual
 - financially responsible for the individual
 - empowered to make financial or health-related decisions on behalf of the individual
 - providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict-of-interest protections the state will implement):*

- 6. **Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.
- 7. **No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.
- 8. **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. Projected Number of Unduplicated Individuals To Be Served Annually.

(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	7/1/2020	12/31/2020	475
Year 2			
Year 3			
Year 4			
Year 5			

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

Financial Eligibility

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

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

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

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

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

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

Evaluation/Reevaluation of Eligibility

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

Directly by the Medicaid agency

●	By Other (<i>specify State agency or entity under contract with the State Medicaid agency</i>):
	Division of Child and Family Services (DCFS), Clark County Department of Family Services (DFS), and Washoe County Human Services Agency (HSA)

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*):

For simplification the term Care Coordinator will be used to encompass either the Child Welfare agency Case Worker, DCFS Care Manager, or DCFS Wraparound Facilitator.

- Youth with the highest level of need receive High Fidelity Wraparound due to intensive behavioral healthcare needs. Youth may possibly be routed to FOCUS or SAFE and may have a Care Manager or Case Worker leading their Child and Family Team (CFT).

The Child Welfare Agency Case worker will determine eligibility within Clark and Washoe Counties. DCFS Care Manager is an all-encompassing term including the Wraparound Facilitator, they are responsible for determining eligibility in the remaining 15 counties in Nevada. However due to a prior recipient relationship, county need, or recipient acuity level the DCFS Care Manager may determine eligibility within Clark and Washoe Counties. This is a fluid process as the state is the safety net provider and when necessary, lends its resources to the counties.

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 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. Bachelor's degree in nursing and Advanced Practitioners of Nursing (APN) (psychiatry);
 - b. Doctorate degree in psychology and license;
 - c. Bachelor's degree in nursing and Advanced Practitioners of Nursing (APN) (psychiatry);
 - d. Independent Nurse Practitioner; Graduate degree in social work and clinical license;
 - e. 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 Coordinator 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 Care Coordinator will review clinical indicators of impaired functioning: Prior psychological assessment records, prior placement history, and prior treatment history.

The Care Coordinator will evaluate whether an individual meets the needs-based State plan HCBS eligibility criteria and whether the individual is eligible for the 1915(i)-state plan benefit.

Re-evaluation occurs every 90 days and based on the individual case.

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

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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):*

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

1. Impaired Functioning & Service Intensity: The Care Coordinator and 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 a minimum CASII or ECSII level of 1.

AND

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

- At risk of higher level of care placement due to recent placement disruption within the past six months;
- Current placement in emergency shelter or congregate care due to behavioral and mental health needs;
- 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
- At risk of higher level of care placement because prior traditional family foster care and/or less restrictive community treatment services have not been successful.

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

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)
Children/youth must need minimum requirements to be considered for 1915(i) services:	The individual’s condition requires services for three of the following: 1. Medication,	In order to meet the ICF-IID level of care criteria, the individual must meet all of the following:	The individual has chronic mental illness and has at least three functional deficits:

<p>1. Impaired Functioning & Service Intensity: The Care Coordinator and 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 Care Coordinator 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 a minimum CASII or ECSII level of 1.</p> <p>AND</p> <p>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 contained in the HCBS</p>	<p>2. Treatment/Special Needs, 3. ADLs, 4. Supervision, or 5. IADLs.</p>	<p>1. Have substantial functional impairments in three (3) or more of six (6) areas of major life activity (mobility, self-care, understanding and use of language, learning, self-direction, and capacity for independent living). For children aged six years and younger, to have intensive support needs in areas of behavioral skills, general skills training, personal care, medical intervention, etc., beyond those required for children of the same age. 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. 3. Must require monthly supports by, or under the supervision of, a health care professional or trained support personnel. 4. The monthly support may be from one entity or may be a combination of supports provided from various sources.</p>	<p>1. Imminent risk of self-harm, 2. Imminent risk of harm to others, 3. Risk of serious medical complications, or 4. Need for 24-hour supervision.</p>
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<p>Benefit, as determined by the DCFS or its designee, as evidenced by at least one of the following risk factors:</p> <ul style="list-style-type: none"> • At risk of higher level of care placement due to recent placement disruption within the past six months; • Current placement in emergency shelter or congregate care due to behavioral and mental health needs; • 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 • At risk of higher level of care placement because prior traditional family foster care and/or less restrictive community treatment services have not been successful. 		<p>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.</p>	
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*Long Term Care/Chronic Care Hospital

**LOC= level of care

7. **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of five years. At least 90 days prior to the end of this five-year period, the state may request CMS renewal of this benefit for additional five-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 the following:

- ✓ Youth must be under 19 years of age at the time of enrollment; they may continue in HCBS benefit through age 19
- ✓ and
- ✓ 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.

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

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

8. **Adjustment Authority.** The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i) (1) (D) (ii).
9. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the person-centered service plan. Specify the state’s policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	Minimum number of services.	The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is:
	1	
ii.	Frequency of services.	The state requires (select one):
<input checked="" type="radio"/>	The provision of 1915(i) services at least monthly	
<input type="radio"/>	Monthly monitoring of the individual when services are furnished on a less than monthly basis	
	If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency:	

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Home and Community-Based Settings

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

1. **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. *(Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a) (1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):*

(Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)

State plan HCBS benefits will be furnished to 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 1915i Operating Agencies: State and County Agencies will verify the settings through a site visit to ensure these homes are compliant with Federal HCB settings requirements at 42 CFR 441.710(a) (1)-(2) prior to enrollment. The SMA will verify the site visit and adherence to the settings rule as part of the enrollment checklist. Further verification of post review is outlined within the plan of quality assurance. Nevada Administrative Code (NAC) 424 requires for an annual inspection of licensed foster homes and adherence to settings rule will be monitored. Additionally, at each six-month check-in the County Caseworker or State Wraparound Facilitator (depending on who completed the eligibility checklist) will go through the settings checklist comprised of the points below with each recipient. Settings which fail to meet the settings criteria will not be able to bill until in compliance; those failing to get into compliance within 30 days will be disenrolled. NAC424 outlines that each foster home shall plan activities that provide for and stimulate social relationship, creative activities, and hobbies. Children with SFC must be afforded an opportunity to participate in neighborhood, school, and other community groups appropriate to the age and needs of each child to the same standard as children not receiving HCBS services. Adherence to NAC424 as outlined before is determined at time of enrollment, annual inspections and at six-month check-in.

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 Coordinator must be independent and must 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 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 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:

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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 will be required to be trained by DCFS in the FOCUS model utilizing the standards of the National Wraparound Implementation Center.

All Care Coordinators will be at least QMHA level or above. 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 either services of CW, CM, or WF based on level of need.

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*):

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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 approach. The CFT team includes the Care Coordinator, 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 Coordinator 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. The CFT shall develop the initial POC, which will be documented by the Care Coordinator. The Care Coordinator will also be responsible for documenting updates to the POC, including recommendations and decisions made by the CFT, in accordance with timeframes as listed in DCFS policy.

The Care Coordinator 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):*

DCFS offers tiered care coordination services to best meet the needs of youth with serious emotional disturbance (SED). Youth with the highest level of need receive High Fidelity Wraparound.

While we anticipate that nearly all youth who are eligible for 1915(i) State plan benefit will also qualify for High Fidelity Wraparound due to intensive behavioral healthcare needs, we have included in this application the possibility that youth may be routed to FOCUS or SAFE and may have a Care Manager or Case Worker leading their Child and Family Team (CFT) and the development of their POC.

Youth with intermediate level of need (not in Washoe or Clark counties) are offered FOCUS Care Coordination, an evidence-informed intermediate level care coordination program created by the National Wraparound Implementation Center which also provides training and technical assistance to Nevada in

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our implementation of High-Fidelity Wraparound. FOCUS Care Coordination is a new, evidence-informed intermediate level care coordination program created by the National Wraparound Implementation Center which also provides training and technical assistance to Nevada in our implementation of High-Fidelity Wraparound. FOCUS care coordination is built around the following elements of service: Families are laughing, i.e. positive relationships are necessary for healing; Outcomes; Coordination; Unconditional positive regard; and Short-term process (FOCUS). Youth receiving FOCUS will have a Care Manager directing the development of the POC.

Youth in Washoe and Clark Counties are offered care coordination utilizing, the Safety Assessment Family Evaluation (SAFE) model. This is a strengths-based, family-centered, and trauma-informed model to inform child welfare agency decision-making. Child safety is the primary focus of the SAFE model, and focus is given to children who may be unsafe based on the presence of uncontrolled danger threats. SAFE uses standardized tools and decision-making criteria to assess family behaviors, conditions, and circumstances, including individual child vulnerabilities and caregiver protective capacities, to make well-founded child safety decisions. The practice model's approach to safety assessment and management recognizes that issues concerned with child safety change as the child protective services intervention proceeds. Youth receiving SAFE will have a Case Worker directing the development of the POC.

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 Coordinator is responsible for working with the participant, family, and team to develop the Plan of Care through the process outlined below.

Within 72 hours of notification of enrollment, the Care Coordinator contacts the participant and family to schedule a face-to-face meeting. At the first meeting between the Care Coordinator, participant, and family after enrollment, the Care Coordinator 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 Coordinator 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 care management 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 to achieve the goals

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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 Coordinator 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 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 Care Coordinator. 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 SAFE, FOCUS, or 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." By signing this form participants acknowledge they have chosen from a list of 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 (MMIS) 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 DHCFP and DCFS reviews and approves the policies, processes and standards for developing and approving the care plan.

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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*):

<input type="checkbox"/>	Medicaid agency	<input checked="" type="checkbox"/>	Operating agency	<input type="checkbox"/>	Case manager
<input checked="" type="checkbox"/>	Other (<i>specify</i>):	DCFS, including their contracted entity, and Local Non-State Entities			

Services

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

Service Specifications (Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):	
Service Title:	Intensive In-Home Supports and Services
Service Definition (Scope):	
<p>Intensive In-Home Supports and Services include:</p> <ul style="list-style-type: none"> ✓ 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 needed behavioral and physical health services and supports in the participant’s person-centered services and support plans. ✓ 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. ✓ 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. <p>Intensive In-Home Supports and Services may serve to reinforce skills, behaviors or lessons taught through other services.</p>	
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):	
<input checked="" type="checkbox"/>	Categorically needy (specify limits):

	<p>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.</p> <p>Service Limitations: Intensive In-Home Services and Supports Without Coaching – Provided in-home by the treatment foster parent(s). Maximum of two hours per day, seven days a week.</p> <p>Service Limitations: Intensive In-Home Services and Supports With Coaching – Provided in-home by a trained coach supporting the treatment foster parent(s) to deliver evidence-based interventions to fidelity. Maximum of one hour per week.</p>
<input type="checkbox"/>	Medically needy (<i>specify limits</i>):
	N/A

Provider Qualifications (<i>For each type of provider. Copy rows as needed</i>):			
Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
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) Certified in State evidence-based model.	Meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to DHCFP Medicaid Services Manual, Chapter 100. Meet all Conditions of Participation in Medicaid Services Manual 102.1.
Specialized Foster Care Agency	Pursuant to 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). Certified in State evidence-based model.	Meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to DHCFP Medicaid Services Manual, Chapter 100. Meet all Conditions of Participation in Medicaid Services Manual 102.1. Agencies must meet all applicable standards listed in NAC 424 and NRS 424.
Child Welfare Jurisdiction	Meet licensure requirements pursuant to DHCFP	Service to be provided at a minimum by a QBA.	Meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to DHCFP Medicaid Services Manual, Chapters 100 and 4000.

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	Medicaid Services Manual.	Certified in State evidence-based model.	
Verification of Provider Qualifications <i>(For each provider type listed above. Copy rows as needed):</i>			
Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>	Frequency of Verification <i>(Specify):</i>	
Intensive Home-based provider	Administrating 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 two years after the date of its issuance and may be renewed upon expiration.	
Child Welfare Jurisdiction	Administrating 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. <i>(Check each that applies):</i>			
<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/>	Provider managed

Service Specifications <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):</i>	
Service Title:	Crisis Stabilization Services
Service Definition (Scope):	
<p>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.</p>	

Additional needs-based criteria for receiving the service, if applicable (<i>specify</i>):			
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):			
<input checked="" type="checkbox"/>	Categorically needy (<i>specify limits</i>):		
	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.		
<input type="checkbox"/>	Medically needy (<i>specify limits</i>):		
	N/A		
Provider Qualifications (<i>For each type of provider. Copy rows as needed</i>):			
Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Specialized Foster Care Agency	Pursuant to NRS 424, an application for a license to operate a foster care agency must be in a form prescribed by the Division and submitted to the appropriate licensing authority.	QMHA under the direction of a QMHP; QMHP	Foster Care Agency providers must be enrolled as a Foster Care Provider Agency through DHCFP’s fiscal agent and meet all required standards listed in the DHCFP Medicaid Services Manual. Agencies must meet all applicable standards listed in NAC 424 and NRS 424.
Child Welfare Jurisdiction	Meet licensure requirements pursuant to DHCFP Medicaid	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 4000.

	Services Manual.		
Verification of Provider Qualifications <i>(For each provider type listed above. Copy rows as needed):</i>			
Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>	Frequency of Verification <i>(Specify):</i>	
Specialized Foster Care Agency	Operating Agency – Division of Child and Family Services Licensing bodies of the foster care homes – DCFS, DFS and HSA	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 two years after the date of its issuance and may be renewed upon expiration.	
Child Welfare Jurisdiction	Administering Agency – Division of Health Care Financing and Policy	Provider contract is effective for 60 months from enrollment date of its issuance and may be renewed upon expiration date.	
Service Delivery Method. <i>(Check each that applies):</i>			
<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/>	Provider managed

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

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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. <i>(Specify criteria):</i>

- 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. <i>(Specify the areas of the state affected by this option):</i>

- 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
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

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

<input checked="" type="radio"/>	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
<input type="radio"/>	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:

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

7. Voluntary and Involuntary Termination of Participant-Direction. *(Describe how the state facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

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8. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can select, manage, and dismiss State plan HCBS providers). *(Select one):*

<input checked="" type="radio"/>	The state does not offer opportunity for participant-employer authority.
<input type="radio"/>	Participants may elect participant-employer Authority <i>(Check each that applies):</i>
<input type="checkbox"/>	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.
<input type="checkbox"/>	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):*

<input checked="" type="radio"/>	The state does not offer opportunity for participants to direct a budget.
<input type="radio"/>	Participants may elect Participant–Budget Authority.
<input type="radio"/>	Participant-Directed Budget. <i>(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.):</i>
<input type="radio"/>	

	<p>Expenditure Safeguards. <i>(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.)</i></p>

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

<p>Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i></p>	<ol style="list-style-type: none"> Operating Agency Administering Agency Quality Assurance (QA)
<p>Frequency</p>	<p>Annually</p>
<p>Remediation</p>	
<p>Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i></p>	<ul style="list-style-type: none"> Operating and Administering Agency will remediate any issue of non-compliance within 90 days of issuance of final monthly report. On a monthly basis, Operating Agency, and Administering Agency’s QA review random samples of case files. If deficiencies are found, Operating Agency will take action as needed through one-on-one education with their contract entity or trainings for the local non-state entities. Copies of the Operating Agency reviews will be submitted to the Administering Agency’s QA and current percentages of compliance, as well as remediations, will be discussed during the monthly QI meeting. QI Team consists of Administering Agency’s Behavioral Health (BH) and QA units, Operating Agency and Local Non-State Entities.
<p>Frequency <i>(of Analysis and Aggregation)</i></p>	<p>Monthly, Quarterly, Annually</p>

<p>Requirement</p>	<p><i>1.b) Service plans are updated annually</i></p>
<p>Discovery</p>	
<p>Discovery Evidence <i>(Performance Measure)</i></p>	<p>Number and percent of service plans that are updated at least once in the last 12 months.</p> <p>N = Number of service plans that are updated at least once in the last 12 months.</p> <p>D = Total number of service plans reviewed.</p>
<p>Discovery Activity <i>(Source of Data & sample size)</i></p>	<p>Remote Desktop Record Reviews for 10% of all recipients active/inactive during review period.</p>
<p>Monitoring Responsibilities</p>	<ol style="list-style-type: none"> Operating Agency Administering Agency QA

<i>(Agency or entity that conducts discovery activities)</i>	
Frequency	Annually
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	<ul style="list-style-type: none"> • Operating and Administering Agency will remediate any issue of non-compliance within 90 days of issuance of final monthly report. • On a monthly basis, Operating Agency and Administering Agency’s QA review random samples of case files. If deficiencies are found, Operating Agency will take action as needed through one-on-one education with their contract entity or trainings for the local non-state entities. Copies of the Operating Agency reviews will be submitted to the Administering Agency’s QA and current percentages of compliance, as well as remediations, will be discussed during the monthly QI meeting. • QI Team consists of Administering Agency’s Behavioral Health (BH) and QA units, Operating Agency and Local Non-State Entities.
Frequency <i>(of Analysis and Aggregation)</i>	Monthly, Quarterly, and Annually

Requirement	<i>1.c) Service plans document choice of services and providers</i>
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	<p>Number and percent of service plans reviewed that indicate 1915(i) participants were given a choice when selecting services.</p> <p>N = Number of service plans reviewed that indicate 1915(i) participants were given a choice when selecting services.</p> <p>D = Total number of service plans reviewed</p>
Discovery Activity <i>(Source of Data & sample size)</i>	Remote Desktop Record Reviews for 10% of all recipients active/inactive during review period.
Monitoring Responsibilities <i>(Agency or entity that</i>	<ol style="list-style-type: none"> 1. Operating Agency 2. Administering Agency QA

<i>conducts discovery activities)</i>	
Frequency	Annually
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	<ul style="list-style-type: none"> Operating and Administering Agency will remediate any issue of non-compliance within 90 days of issuance of final monthly report. On a monthly basis, Operating Agency and Administering Agency’s QA review random samples of case files. If deficiencies are found, Operating Agency will take action as needed through one-on-one education with their contract entity or trainings for the local non-state entities. Copies of the Operating Agency reviews will be submitted to the Administering Agency’s QA and current percentages of compliance, as well as remediations, will be discussed during the monthly QI meeting. QI Team consists of Administering Agency’s Behavioral Health (BH) and QA units, Operating Agency and Local Non-State Entities.
Frequency <i>(of Analysis and Aggregation)</i>	Monthly, Quarterly, and Annually

Discovery Evidence <i>(Performance Measure)</i>	<p>Number and percent of service plans reviewed that indicate 1915(i) participants were given a choice when selecting providers.</p> <p>$N = \text{Number of service plans reviewed that indicate 1915(i) participants were given a choice when selecting providers.}$</p> <p>$D = \text{Total number of service plans reviewed}$</p>
Discovery Activity <i>(Source of Data & sample size)</i>	Remote Desktop Record Reviews for 10% of all recipients active/inactive during review period.
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	<ol style="list-style-type: none"> Operating Agency Administering Agency QA
Frequency	Annually

Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	<ul style="list-style-type: none"> Operating and Administering Agency will remediate any issue of non-compliance within 90 days of issuance of final monthly report. On a monthly basis, Operating Agency and Administering Agency’s QA review random samples of case files. If deficiencies are found, Operating Agency will take action as needed through one-on-one education with their contract entity or trainings for the local non-state entities. Copies of the Operating Agency reviews will be submitted to the Administering Agency’s QA and current percentages of compliance, as well as remediations, will be discussed during the monthly QI meeting. QI Team consists of Administering Agency’s Behavioral Health (BH) and QA units, Operating Agency and Local Non-State Entities.
Frequency <i>(of Analysis and Aggregation)</i>	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 <i>(Performance Measure)</i>	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. N: Number of new applicants who had an evaluation indicating the individual met the 1915(i) needs-based eligibility criteria prior to receiving services. D: Number of new applicants receiving 1915(i) services reviewed.
Discovery Activity <i>(Source of Data & sample size)</i>	Remote Desktop Record Reviews for 10% of all recipients active/inactive during review period.
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	1. Operating Agency 2. Administering Agency BH
Frequency	Monthly, Quarterly and Annually
Remediation	

<p>Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i></p>	<ul style="list-style-type: none"> Operating Agency will advise the Administering Agency BH of issues as they occur and will remediate any issues of non-compliance within 90 days.
<p>Frequency <i>(of Analysis and Aggregation)</i></p>	<p>Monthly, Quarterly, Annually</p>

<p>Discovery</p>	
<p>Discovery Evidence <i>(Performance Measure)</i></p>	<p>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.</p> <p>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.</p> <p>D: Number of 1915(i) applicants</p>
<p>Discovery Activity <i>(Source of Data & sample size)</i></p>	<p>Remote Desktop Record Reviews for 10% of all recipients active/inactive during review period.</p>
<p>Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i></p>	<ol style="list-style-type: none"> Operating Agency Administering Agency BH
<p>Frequency</p>	<p>Monthly, Quarterly and Annually</p>
<p>Remediation</p>	
<p>Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates</i></p>	<ul style="list-style-type: none"> Operating Agency will advise the Administering Agency BH of issues as they occur and will remediate any issues of non-compliance within 90 days.

<i>remediation activities; required timeframes for remediation)</i>	
Frequency <i>(of Analysis and Aggregation)</i>	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 <i>(Performance Measure)</i>	Number and percent of reviewed 1915(i) evaluations that were completed using the processes and instruments approved in the 1915(i) HCBS state plan. N = Number of reviewed 1915(i) evaluations that were completed using the processes and instruments approved in the 1915(i) HCBS state plan. D = Total number of 1915(i) evaluations reviewed
Discovery Activity <i>(Source of Data & sample size)</i>	Remote Desktop Record Reviews for 10% of all recipients active/inactive during review period.
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	1. Operating Agency 2. Administering Agency QA
Frequency	Annually
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required</i>	<ul style="list-style-type: none"> Operating and Administering Agency will remediate any issue of non-compliance within 90 days of issuance of final monthly report. On a monthly basis, Operating Agency and Administering Agency’s QA review random samples of case files. If deficiencies are found, Operating Agency will take action as needed through one-on-one education with their contract entity or trainings for the local non-state entities. Copies of the Operating Agency reviews will be submitted to the Administering Agency’s QA and current percentages of compliance, as well as remediations, will be discussed during the monthly QI meeting.

<i>timeframes for remediation)</i>	<ul style="list-style-type: none"> • QI Team consists of Administering Agency’s Behavioral Health (BH) and QA units, Operating Agency and Local Non-State Entities.
Frequency <i>(of Analysis and Aggregation)</i>	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
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Discovery

Discovery Evidence <i>(Performance Measure)</i>	<p>Number and percentage of enrolled recipients whose 1915 (i) benefit Needs Based eligibility Criteria, was reevaluated annually.</p> <p>N: Number of enrolled recipients whose Needs Based Criteria was reevaluated annually;</p> <p>D: Number of enrolled recipients reviewed.</p>
Discovery Activity <i>(Source of Data & sample size)</i>	Remote Desktop Record Reviews for 10% of all recipients active/inactive during review period.
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	<ol style="list-style-type: none"> 1. Operating Agency 2. Administering Agency QA
Frequency	Annually

Remediation

Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	<ul style="list-style-type: none"> • Operating and Administering Agency will remediate any issue of non-compliance within 90 days of issuance of final monthly report. • On a monthly basis, Operating Agency and Administering Agency’s QA review random samples of case files. If deficiencies are found, Operating Agency will take action as needed through one-on-one education with their contract entity or trainings for the local non-state entities. Copies of the Operating Agency reviews will be submitted to the Administering Agency’s QA and current percentages of compliance, as well as remediations, will be discussed during the monthly QI meeting. • QI Team consists of Administering Agency’s Behavioral Health (BH) and QA units, Operating Agency and Local Non-State Entities.
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Frequency <i>(of Analysis and Aggregation)</i>	Quarterly, Annually, Continuously and Ongoing
Requirement	Providers meet required qualifications.
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Number and percent of 1915(i) providers who meet the State’s certification standards, as required, prior to providing 1915(i) services. N: Number of 1915(i) providers who meet the State’s certification standards, as required, prior to providing 1915(i) services. D: Total number of 1915(i) providers reviewed.
Discovery Activity <i>(Source of Data & sample size)</i>	Remote Desktop Record Reviews for 100% of all Providers active/inactive during review period.
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	<ol style="list-style-type: none"> 1. Administering Agency Provider Enrollment 2. Administering Agency Behavioral Health Unit 3. Fiscal Agent Contractor 4. Operating Agency
Frequency	Initially and Upon re-validation
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	<ul style="list-style-type: none"> • Operating and Administering Agency will remediate any issue of non-compliance within 30 days • All provider enrollment applications and revalidations are submitted electronically through the Provider Portal. The Fiscal Agent and SMA Provider Enrollment Unit monitor and review all applications and documents and make appropriate action as needed.
Frequency	Initially and Annually or on Revalidation schedule

<i>(of Analysis and Aggregation)</i>	
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 <i>(Performance Measure)</i>	Number and percent of HCBS settings that meet Federal HCBS settings requirements. N: Number of HCBS settings that meet Federal HCBS settings requirements. D: Total # of HCBS settings providing 1915(i) services.
Discovery Activity <i>(Source of Data & sample size)</i>	Remote Desktop/ On Site Record Reviews for 100% of all active settings during a review period..
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	<ol style="list-style-type: none"> 1. Operating Agency 2. Local Non-State Entity and Operating Agency Licensing Workers 3. Administering Agency
Frequency	Bi-Annually
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	<ul style="list-style-type: none"> • Operating and Administering Agency will remediate any issue of non-compliance within 30 days.
Frequency <i>(of Analysis and Aggregation)</i>	Bi-Annually

Requirement	5. The SMA retains authority and responsibility for program operations and oversight.
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	<p>Number and percent of issues identified in contract monitoring reports that were remediated as required by the state.</p> <p>N = Number of issues identified in contract monitoring reports that were remediated as required by the State.</p> <p>D = Total number of issues identified.</p>
Discovery Activity <i>(Source of Data & sample size)</i>	Remote Desktop Record Review for 10% of all open provider applications/contracts.
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	<ol style="list-style-type: none"> 1. Administering Agency BH 2. Administering Agency Analytics Team
Frequency	Annually taken from the monthly analysis
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	<ul style="list-style-type: none"> • Annually the Administering Agency reviews a random sample of all open provider applications and contract. If deficiencies are found, Administering Agency will advise the Operating Agencies and Provider of the items needing remediation. • SMA will remediate any issue or non-compliance within 90 days.
Frequency <i>(of Analysis and Aggregation)</i>	Annually taken from the monthly analysis
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	

<p>Discovery Evidence <i>(Performance Measure)</i></p>	<p>Number and percent of claims paid to 1915(i) service providers who are qualified to furnish 1915(i) services to 1915(i) recipients. N: Number of claims paid to 1915(i) service providers who are qualified to furnish 1915(i) services to 1915(i) recipients. D: Number of claims reviewed.</p>
<p>Discovery Activity <i>(Source of Data & sample size)</i></p>	<p>Remote Desktop Financial Record Reviews for 10% of all paid claims during review period.</p>
<p>Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i></p>	<p>Administering Agency QA</p>
<p>Frequency</p>	<p>Annually</p>
<p>Remediation</p>	
<p>Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i></p>	<ul style="list-style-type: none"> Administering Agency QA will provide issues and discrepancies found within the randomly selected month’s billings to the Administering Agency’s Surveillance and Utilization Review (SUR) unit to review and determine extent of issue. Administering Agency SUR will remediate any issue of non-compliance within 12 Months of notification by using Recoupment or Letters of Instructions.
<p>Frequency <i>(of Analysis and Aggregation)</i></p>	<p>Annually</p>

<p>Discovery</p>	
<p>Discovery Evidence <i>(Performance Measure)</i></p>	<p>Number and percent of claims verified through a review of provider documentation that have been paid in accordance with the individual’s service plan. N: Number of claims verified through a review of provider documentation that have been paid in accordance with the individual’s service plan. D: Total number of claims reviewed.</p>
<p>Discovery Activity</p>	<p>Remote Desktop Financial Record Reviews for 10% of all paid claims during review period.</p>

<p><i>(Source of Data & sample size)</i></p>	
<p>Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i></p>	<p>Administering Agency QA</p>
<p>Frequency</p>	<p>Annually</p>
<p>Remediation</p>	
<p>Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i></p>	<ul style="list-style-type: none"> Administering Agency QA will provide issues and discrepancies found within the randomly selected month’s billings to the Administering Agency’s Surveillance and Utilization Review (SUR) unit to review and determine extent of issue. Administering Agency SUR will remediate any issue of non-compliance within 12 Months of notification by using Recoupment or Letters of Instructions.
<p>Frequency <i>(of Analysis and Aggregation)</i></p>	<p>Annually</p>
<p>Requirement</p>	<p>7. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation.</p>
<p>Discovery</p>	
<p>Discovery Evidence <i>(Performance Measure)</i></p>	<p>Number and percent of 1915(i) recipients who receive information/education about how to report abuse, neglect, exploitation and other critical incidents. N: Number of recipients who received information or education about how to report abuse, neglect, exploitation and other critical incidents. D: Number of participants reviewed.</p>
<p>Discovery Activity <i>(Source of Data & sample size)</i></p>	<p>Remote Desktop Record Reviews for 100% of all recipients active/inactive during review period.</p>
<p>Monitoring Responsibilities <i>(Agency or entity that conducts</i></p>	<ol style="list-style-type: none"> Operating Agency Administering Agency QA Administering Agency BH

<i>discovery activities)</i>	
Frequency	Annually, Continuously and Ongoing
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	<ul style="list-style-type: none"> Operating and Administering Agency will remediate any issue of non-compliance within 30 days. 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 review as requested by administrating and operating agencies. <p>QI Team consists of Administering Agency’s BH and QA units, and Operating Agency</p>
Frequency <i>(of Analysis and Aggregation)</i>	Monthly, Quarterly, Annually

Discovery	
Discovery Evidence <i>(Performance Measure)</i>	<p>Number and percent of incident reviews/investigations that were initiated regarding unexplained deaths, abuse, neglect, exploitation and unapproved restraints as required by the SMA.</p> <p>N: Number of incident reviews/investigations that were initiated regarding unexplained deaths, abuse, neglect, exploitation and unapproved restraints as required by the SMA.</p> <p>D: Number of incidents reviewed.</p>
Discovery Activity <i>(Source of Data & sample size)</i>	Remote Desktop Record Reviews for 100% of all recipients active/inactive during review period.
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	<ol style="list-style-type: none"> Operating Agency, including their contracted entity Local non-state entities Administering Agency BH
Frequency	Annually, Continuously and Ongoing
Remediation	

<p>Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i></p>	<p>Operating and Administering Agency will remediate any issue of non-compliance w/in 30 days All Serious Occurrence Reports (SOR) must be reported within 24 hours of discovery. All SORs are entered into an approved SORS database including follow-ups by Care Coordinators. On a weekly basis or as needed, administering and operating agencies will review and approve follow-ups to ensure appropriate action is taken and the health and safety of the recipients have been addressed timely. Reports are generated upon request.</p> <p>Within five business days, Care Coordinators will conduct all necessary follow-ups to include plan of correction, report submitted to law enforcement, CPS or Health Care Quality and Compliance (HCQC) if applicable.</p> <p>The administering and operating agencies will review SORs on a weekly or as needed basis.</p>
<p>Frequency <i>(of Analysis and Aggregation)</i></p>	<p>Monthly, Quarterly, Annually</p>

<p>Discovery</p>	
<p>Discovery Evidence <i>(Performance Measure)</i></p>	<p>Number and percent of incident reviews/investigations involving unexplained deaths, abuse, neglect, exploitation and unapproved restraints for recipients that were completed by the SMA.</p> <p>N: Number of incident reviews/investigations involving unexplained deaths, abuse, neglect, exploitation and unapproved restraints for recipients that were completed by the SMA.</p> <p>D: Number of incidents reviewed.</p>
<p>Discovery Activity <i>(Source of Data & sample size)</i></p>	<p>Remote Desktop Record Reviews for 100% of all recipients active/inactive during review period.</p>
<p>Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i></p>	<ol style="list-style-type: none"> 1. Operating Agency, including their contracted entity 2. Local non-state entities 3. Administering Agency BH
<p>Frequency</p>	<p>Annually, Continuously and Ongoing</p>
<p>Remediation</p>	
<p>Remediation Responsibilities</p>	<p>Operating and Administering Agency will remediate any issue or non-compliance within 30 days.</p>

<p><i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i></p>	<p>All Serious Occurrence Reports (SOR) must be reported within 24 hours of discovery. All SORs are entered into an approved SORs database, including follow-ups by Care Coordinators. On a weekly basis or as needed, administering and operating agencies will review and approve follow-ups to ensure appropriate action is taken and the health and safety of the recipients have been addressed timely. Reports are generated upon request.</p> <p>Within 5 business days, Care Coordinators will conduct all necessary follow-ups to include plan of correction, report submitted to law enforcement, CPS or Health Care Quality and Compliance (HCQC) if applicable.</p> <p>The administering and operating agencies will review SORs on a weekly or as needed basis.</p>
<p>Frequency <i>(of Analysis and Aggregation)</i></p>	<p>Monthly, Quarterly, Annually</p>

<p>Discovery</p>	
<p>Discovery Evidence <i>(Performance Measure)</i></p>	<p>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.</p> <p>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.</p> <p>D: Number of incidents reviewed.</p>
<p>Discovery Activity <i>(Source of Data & sample size)</i></p>	<p>Remote Desktop Record Reviews for 100% of all recipients active/inactive during review period.</p>
<p>Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i></p>	<ol style="list-style-type: none"> 1. Operating Agency, including their contracted entity 2. Local non-state entities 3. Administering Agency BH
<p>Frequency</p>	<p>Annually, Continuously and Ongoing</p>
<p>Remediation</p>	
<p>Remediation Responsibilities <i>(Who corrects, analyzes, and</i></p>	<p>Operating and Administering Agency will remediate any issue or non-compliance within 30 days.</p> <p>All Serious Occurrence Reports (SOR) must be reported within 24 hours of discovery. All SORs are entered into an approved SORs database, including</p>

<p><i>aggregates remediation activities; required timeframes for remediation)</i></p>	<p>follow-ups by Care Coordinators. On a weekly basis or as needed, administering and operating agencies will review and approve follow-ups to ensure appropriate action is taken and the health and safety of the recipients have been addressed timely. Reports are generated upon request.</p> <p>Within 5 business days, the 1915(i) HCC will conduct all necessary follow-ups to include plan of correction, report submitted to law enforcement, CPS or Health Care Quality and Compliance (HCQC) if applicable.</p> <p>The administering and operating agencies will review SORs on a weekly or as needed basis.</p>
<p>Frequency <i>(of Analysis and Aggregation)</i></p>	<p>Monthly, Quarterly, Annually</p>

System Improvement

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

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

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

Case Management records are in a case management database which generates reports needed for QA case file reviews. Provider records are managed through the Medicaid Management Information System (MMIS) and reviewed by the SMA Fiscal Agent and Provider Enrollment Unit. Electronic submission of claims 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 Child Welfare (CPS) which is monitored and reviewed by the Operating Agencies Care Coordinator Supervisors.

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.