ANNUAL STATEWIDE 1915(i) HOME AND COMMUNITY BASED SERVICES (HCBS) INTENSIVE IN-HOME SUPPORTS AND SERVICES AND CRISIS STABILIZATION SERVICES, SPECIALIZED FOSTER CARE (SFC) REVIEW FINAL REPORT

HCBS Serving Individuals enrolled in IHSS and CSS Quality Assurance (QA) review to ensure the service continues to meet essential federal statutory assurances and effectively meet the recipient's needs.

State of Nevada
Division of Health Care Finance and Policy
Quality, Access and Availability Unit
December 2023
Review Year: State Plan Years 1, 2 and 3

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Background/Introduction

The State Plan Amendment (SPA) renewal of the Specialized Foster Care (SFC) is contingent on the Centers for Medicare and Medicaid Services (CMS) determining that the state has effectively assured the health and welfare of state plan recipients during the period the SPA has been in effect.

The state is required under 1915(i)(1)(H)(i) to ensure that the provision of state plan HCBS meets federal and state guidelines for quality assurance. In addition, under 42 Code of Federal Regulation (CFR) §441.745: "States must develop and implement an HCBS quality improvement strategy that includes a continuous improvement process and measures of program performance and experience of care. The strategy must be proportionate to the scope of services in the state plan HCBS benefit and the number of individuals to be served." CMS must assess each state plan HCBS benefit to determine that the state requirements are met. The assessment also serves to inform CMS in its review of the state's request for renewal of these services.

CMS conducts quality reviews, requiring states to demonstrate their use of performance measures to collect HCBS data and address how they conduct discovery, remediation, and quality improvement activities.

A state must demonstrate oversight through performance measures included in its §1915(i) state plan HCBS benefit. When a performance measure falls below the threshold of eighty-six percent (86%), further analysis is required to determine the cause and the Quality Management Activities implemented unless the state provides acceptable justification clarifying why system improvement is not necessary.

Performance Measures

CMS evaluates the state's oversight and monitoring systems according to outcome-based evidence in the form of performance measures. Well-crafted performance measures indicate whether the state is meeting the federal requirements for the approved SPA benefit. The performance measures drive the state's Quality Improvement Strategy (QIS) and form the basis of the evidence provided to CMS.

The state's performance measures are assessed by CMS based on the following seven criteria:

1. The performance measure is stated as a metric (e.g., number or percent), and specifies a numerator and denominator (i.e., is the performance measure measurable?).
2. The performance measure has face validity (i.e., Does the performance measure truly measure the requirement?).
3. The performance measure data is based on the correct unit of analysis (e.g., participants, providers, claims, etc.). The unit of analysis should be linked to the requirement measured.
4. The performance measure data is based on a representative sample of the population. CMS approved a reduction in reviews needed to a ten percent (10%) review of all recipients active/inactive during the review period. If the state chooses to stratify a sample to allow for a representative sample of subgroups, the state must "re-weight" the data in order to make estimates for the population as a whole.
5. The performance measure must provide data specific to the state plan benefit undergoing evaluation.
6. The performance measure data demonstrates the degree of compliance for each period of data collection.
7. The performance measure determines the health of the system, (e.g., does the performance measure evaluate the anticipated outcome of the requirement as opposed to measuring a beginning step in the process?).

Aims & Objectives

The annual review monitoring activities provide the foundation for quality improvement by generating information regarding compliance, potential problems, and individual corrective actions. The results can be aggregated and analyzed to measure the overall system performance in meeting the service assurances.

Methodology

CMS quality requirements are founded on an evidence-based approach. CMS requests evidence from the state that it meets the assurances and applies a continuous quality improvement approach to the assurances. The Division of Health Care Financing and Policy (DHCFP) Quality Assurance (QA) Unit implemented a monthly process to allow the state to achieve higher administrative efficiency, a natural process of current and continuous quality improvement, and prevent duplication. The DHCFP QA unit uses a representative sample. Effective March 29, 2023, CMS approved an amendment to the SPA allowing a ten percent (10%) sample size. The sample size is used to determine the required number of recipient cases that DHCFP QA and Operating Agency, Division of Child and Family Services (DCFS), staff will evaluate. The total number of reviews are split between DHCFP QA and DCFS. All recipients' cases selected for State Plan Years One (1), Two (2) and Three (3) were evaluated during the months of October and November 2023. The ten percent (10%) sample size was also used to determine the required number of financials DHCFP

QA would review for each state plan year. All financial reviews were also evaluated during the months of October and November 2023.

The annual review period for the HCBS SFC State Plan Year One (1) was July 1, 2020 through June 30, 2021. As SFC was a new State Plan, approved August 7, 2020 with an effective date of July 1, 2020, there were no providers onboarded to provide services to recipients and the first provider billing occurred in August 2021, as such there was no data to review for year one (1).

The annual review period for the HCBS SFC State Plan Year Two (2) was July 1, 2021, through June 30, 2022. The ten percent (10%) review requirement determined a sample size of fifty-four (54) reviews. Twenty-seven (27) reviews assigned and completed by the DHCFP QA unit, and the remaining twenty-seven (27) reviews assigned and completed by the Operating Agency, DCFS. The DHCFP QA unit reviewed fifty-four (54) recipients for a total of one hundred twelve (112) financial claims, wherein three (3) had no billed claims and one (1) recipient was a duplication.

The annual review period for the HCBS SFC State Plan Year Three (3) was July 1, 2022, through June 30, 2023. The ten percent (10%) review requirement determined a sample size of sixty-four (64) reviews. Thirty-two (32) reviews assigned and completed by the DHCFP QA unit, and the remaining thirty-two (32) reviews assigned and completed by the Operating Agency, DCFS. The DHCFP QA unit reviewed sixty-four (64) recipients for a total of one hundred fifty (150) financial claims, wherein four (4) had no billed claims and one (1) recipient was a duplication.

The following areas were evaluated during this year's annual review:

Case File Review:

1. State Plan Eligibility
2. State Plan Service Received
3. Plan of Care (POC)

Financial Review:

1. Recipient Eligibility
2. Claim
3. Progress Notes
4. Payment

The case file review and the financial review forms were created to reflect current policy to ensure accurate reporting.

Listed below are the specific policies used in the implementation of this annual review:

- MSM Chapter 4000 HCBS State Plan Option Intensive In-Home Services and Crisis Stabilization (Effective 10/27/2021)
- MSM Chapter 3300 Program Integrity (Effective 05/01/2019)
- State Plan: 1915(i) HCBS State Plan Services (Initial Approval effective 07/01/2020, Amended effective 07/01/2021, and Amended effective 03/29/2023)
- 42 CFR 441.710, CFR 441.715, CFR 441.720, CFR 441.725 and CFR 441.730
- Nevada Administrative Code (NAC) 424
- Nevada Revised Statutes (NRS) Chapter 424

The following results identify the areas and percentages of compliance with performance measures and requirements outlined in the above documents.

State Plan Year 2 (2021) Results

2021 Statewide Case File Review Results SFC

Eligibility	Meets the needs-based eligibility requirements Biopsychosocial Assessment (ESSII or CASII/SED) AND at Least 1 Risk Factor	84.7%
	Eligibility Re-evaluation completed: CASII or ECSII every 90 days	42.8%
SFC Plan of Care (POC)	Was there a POC provided	76.9%
	POC was specific/measurable/achievable	71.9%
	POC addresses assessed needs	79.9%
	POC created within 45 days of removal or Agency decision to provide in-home services (effective 06/09/2022)	30.3%
	POC reevaluated every 90 days (thru 06/08/22) POC reevaluated every 6 months (effective 06/09/22)	0%
	POC updated annually or more frequently as needed	0%
	Amount/Scope/Duration for each service (IIHS) Amount/Frequency/Duration for each service (CSS)	31.7%
	POC signed by CFT members: Caregiver, Support Persons, Child/youth (as applicable), Care Coordinator and Service Provider	58.7%
	POC documents choice of providers/services	62.0%

2021 Findings

Findings identify areas of deficiency discovered through the completion of the Annual Statewide SFC State Plan Review. The following findings are provided as guidance to focus development on building best practices for quality improvement:

Case File Review Results

CMS requires quality improvement projects/remediation when the threshold of compliance is below eighty-six percent (86%). For the 2021 review period, ten (10) elements have been identified as needing further analysis by the Quality Improvement (QI) committee.

- Meets the needs-based eligibility requirements: 85%
- Eligibility re-evaluation completed every 90 days: 43%
- POC was specific/measurable/achievable: 72%
- POC addressed assessed needs: 80%
- POC created within 45 days of removal or Agency decision to provide in-home services: 30%
- POC reevaluated every 90 days (thru 06/08/22)
  POC reevaluated every 6 months (effective 06/09/22): 0%
- POC updated annually or more frequently as needed: 0%
- Amount/Scope/Duration for each service (IIHS)
  Amount/Frequency/Duration for each service (CSS): 32%
- POC signed by Child and Family Team (CFT) members: Caregiver, Support Persons, child/youth (as applicable), Care Coordinator and Service Provider: 59%
- POC documents choice of providers/services: 62%

State Plan Year 3 (2022) Results

2022 Statewide Case File Review Results SFC

Eligibility	Meets the needs-based eligibility requirements Biopsychosocial Assessment (ESSII or CASII/SED) AND at Least 1 Risk Factor	86.9%
	Eligibility Re-evaluation completed: CASII or ECSII every 90 days	2.3%
SFC Plan of Care (POC)	Was there a POC provided	75.4%
	POC is Person Centered (effective 03/17/2023)	40.7%
	POC was specific/measurable/achievable	62.3%
	POC addresses assessed needs	52.9%
	POC created within 45 days of removal or Agency decision to provide in-home services (effective 06/09/2022)	45.9%
	POC reevaluated every 90 days (thru 06/08/22) POC reevaluated every 6 months (effective 06/09/22)	0.2%
	POC updated annually or more frequently as needed	33.3%
	Amount/Scope/Duration for each service (IIHS) Amount/Frequency/Duration for each service (CSS)	18.0%
	POC signed by CFT members: Caregiver, Support Persons, Child/youth (as applicable), Care Coordinator and Service Provider	43.4%
	POC documents choice of providers/services	52.9%

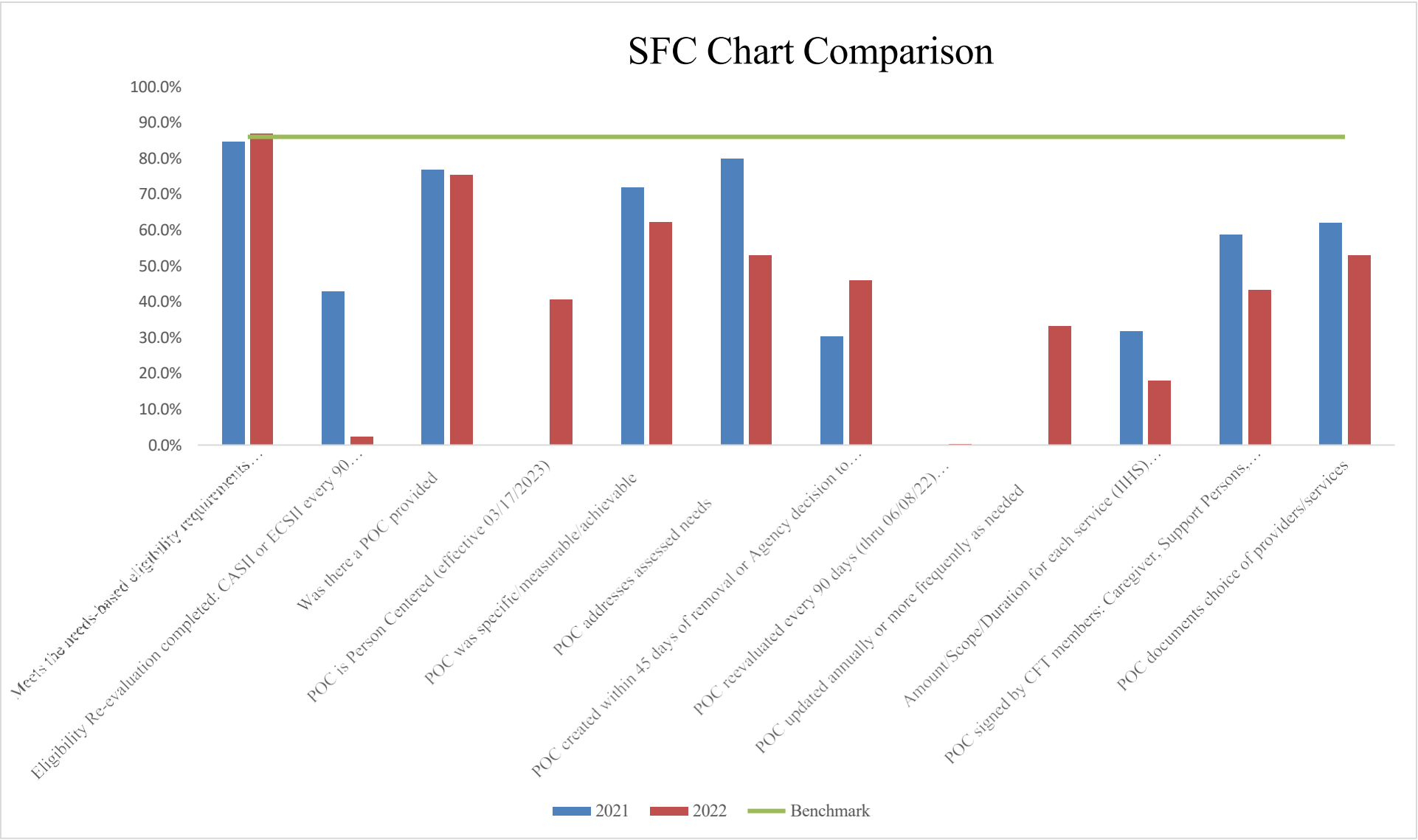
2022 Findings

Findings identify areas of deficiency discovered through the completion of the Annual Statewide SFC State Plan Review. The following findings are provided as guidance to focus development on building best practices for quality improvement:

Case File Review Results

CMS requires quality improvement projects/remediation when the threshold of compliance is below eighty-six percent (86%). For the 2022 review period, ten (10) elements have been identified as needing further analysis by the Quality Improvement (QI) committee.

- Eligibility re-evaluation completed every 90 days: 2%
- POC is Person Centered (effective 03/17/2023): 41%
- POC was specific/measurable/achievable: 62%
- POC addressed assessed needs: 53%
- POC created within 45 days of removal or Agency decision to provide in-home services: 46%
- POC reevaluated every 90 days (thru 06/08/22)
  POC reevaluated every 6 months (effective 06/09/22): 0.2%
- POC updated annually or more frequently as needed: 33%
- Amount/Scope/Duration for each service (IIHS)
  Amount/Frequency/Duration for each service (CSS): 18%
- POC signed by Child and Family Team (CFT) members: Caregiver, Support Persons, child/youth (as applicable), Care Coordinator and Service Provider: 43%
- POC documents choice of providers/services: 53%


SFC Chart Comparison
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Meets the needs-based eligibility requirements…
Eligibility Re-evaluation completed: CASII or ECSII every 90…
Was there a POC provided
POC is Person Centered (effective 03/17/2023)
POC was specific/measurable/achievable
POC addresses assessed needs
POC created within 45 days of removal or Agency decision to…
POC reevaluated every 90 days (thru 06/08/22)…
POC updated annually or more frequently as needed
Amount/Scope/Duration for each service (IHHS)…
POC signed by CFT members: Caregiver, Support Persons,…
POC documents choice of providers/services
2021
2022
Benchmark

2021 vs 2022 Case File Review Comparison

For 2022, improvement was noted for three (3) components from the previous 2021 review period. The top three (3) areas of improvement include: “POC created within 45 days of removal or Agency decision to provide in-home services” at forty-six percent (46%), increasing sixteen percent (16%), “Meets the needs-based eligibility requirements” at eighty-one percent (87%), increasing two percent (2%), and “POC updated annually or more frequently as needed”, at seventy-eight (78%) increasing thirty-three percent (33%).

One (1) review element is at or above the eighty-sixth percentile (86%) with nine (9) remaining elements below the eighty-sixth percentile (86%).

Quality Improvement Project Performance

(Percentages calculated by total number provided over the total number required.)

Requirement 1: Plan of Care (POC)
a) address assessed needs of 1915(i) participants; b) are updated annually; c) document choice of services and providers.

- Sub-requirement 1-a Service plans address assessed needs of 1915(i) participants.
  Review Question 7: POC addresses assessed needs.

2020	N/A
2021	79.9%
2022	52.9%

- Sub-requirement 1-b Service plans are updated annually.
  Review Question 10: POC updated annually or more frequently as needed.

2020	N/A
2021	0%
2022	33.3%

- Sub-requirement 1-c Service plans document choice of services and providers.
  Review Question 13: POC documents choice of providers/services.

2020	N/A
2021	62.0%
2022	52.9%

Requirement 2: Eligibility Requirements
a) an evaluation for 1915(i) state plan HCBS eligibility is provided to all applicants for whom there is a reasonable indication that 1915(i) services may be needed in the future; b) the process 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 state plan for 1915(i) HCBS

- Sub-requirement 2-b The process and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately.
  Review Question 2: Annually meets the needs-based eligibility requirements, *Biopsychosocial Assessment (ESSII or CASII/SED) AND At Least 1 Risk Factor.*

2020	N/A
2021	84.7%
2022	86.9%

- Sub-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.
  Review Question 3: Eligibility re-evaluation completed every 90 days.

2020	N/A
2021	42.8%
2022	2.3%

Recommendations & Observations

Recommendations are suggestions to help improve the effectiveness and quality of waiver operations. The following recommendations are provided as guidance to develop best practices for continuing quality improvement:

- DHCFP QA will hold monthly Quality Improvement (QI) meetings with Administration, Operations and each of the Counties and State case management providers to disseminate information, review trends and track results from completed case file reviews.
- In an effort to mitigate errors from 2021 and 2022, Administration and Operations will need to meet to discuss policies in depth and ensure accuracy of requirements align with current practices while being compliant with federal and state guidelines.
- Administration and Operations will hold meetings with county and state supervisors to discuss deficiencies and make remediation plans and trainings as necessary.
- Administration and Operations will discuss recipient selection due to changing of names and Medicaid numbers of the recipients to avoid duplication of recipients.
- During the review process it was noted that the care coordinators were requesting the POCs from the Providers. As policy states the care coordinators are responsible for updating and maintaining the POC, it will be stressed in QI Meetings the importance of having the plans stored within the county or state care coordinators file.
- Missing, or failure to provide, required documentation contributed to errors within plan and eligibility reviews. Stressing the importance of maintaining and providing this documentation should bring these numbers up in the next state plan review period.

State Plan Year 2 (2021) Financial Results

2021 Statewide Financial Review Results for SFC

Eligibility	Meets the needs-based eligibility requirements: Biopsychosocial Assessment	84.8%
	Any conflicting services provided during the review month/service dates*	98.2%
Claim	Procedure code correct	98.2%
	Service units billed fall within the POC units allowed	98.2%
	Service units/days provided match units/days billed and for which payment was received	91.1%
Services	Services provided match the POC	98.2%
	Frequency of services match the POC	98.2%
Progress Notes	The name of the individual receiving services. If the services are in a group setting	98.2%
	The place of service	93.8%
	Date the service was delivered	98.2%
	Beginning and ending times the service was delivered	96.4%
	The provider that delivered service and their credentials	28.6%
	The signature of each provider	98.2%
	The goals and objectives that were discussed and provided	98.2%
	A statement assessing the recipient's progress towards attaining the identified treatment goals	98.2%
Payment	Payment to provider correct based on claim submitted	89.3%
	Services paid according to the Medicaid rate	100%
	Overpayment to provider*	89.3%
	Referral made to Surveillance and Utilization Review (SUR) Unit*	89.3%

**Denotes compliance and not percentage of overpayments.*

2021 Financial Review Results

Findings identify areas of deficiency discovered through the completion of the Annual Statewide SFC State Plan Review. The following findings are provided as guidance to focus development on building best practices for quality improvement:

Financial Review Results

CMS requires quality improvement projects/remediation when the threshold of compliance is below eighty-six percent (86%). For the 2021 review period, two (2) elements have been identified as needing further analysis.

- Meets the needs-based eligibility requirements: 85%
- The provider that delivered service and their credentials: 29%

State Plan Year 3 (2022) Financial Results

2022 Statewide Financial Review Results for SFC

Eligibility	Meets the needs-based eligibility requirements: Biopsychosocial Assessment	47.3%
	Any conflicting services provided during the review month/service dates*	98.7%
Claim	Procedure code correct	98.0%
	Service units billed fall within the POC units allowed	98.0%
	Service units/days provided match units/days billed and for which payment was received	94.0%
Services	Services provided match the POC	96.0%
	Frequency of services match the POC	95.3%
Progress Notes	The name of the individual receiving services. If the services are in a group setting	95.3%
	The place of service	80.7%
	Date the service was delivered	95.3%
	Beginning and ending times the service was delivered	94.7%
	The provider that delivered service and their credentials	46.7%
	The signature of each provider	95.3%
	The goals and objectives that were discussed and provided	95.3%
	A statement assessing the recipient's progress towards attaining the identified treatment goals	94.7%
Payment	Payment to provider correct based on claim submitted	92.7%
	Services paid according to the Medicaid rate	100%
	Overpayment to provider*	92.7%
	Referral made to Surveillance and Utilization Review (SUR) Unit*	92.7%

* *Denotes compliance and not percentage of overpayments.*

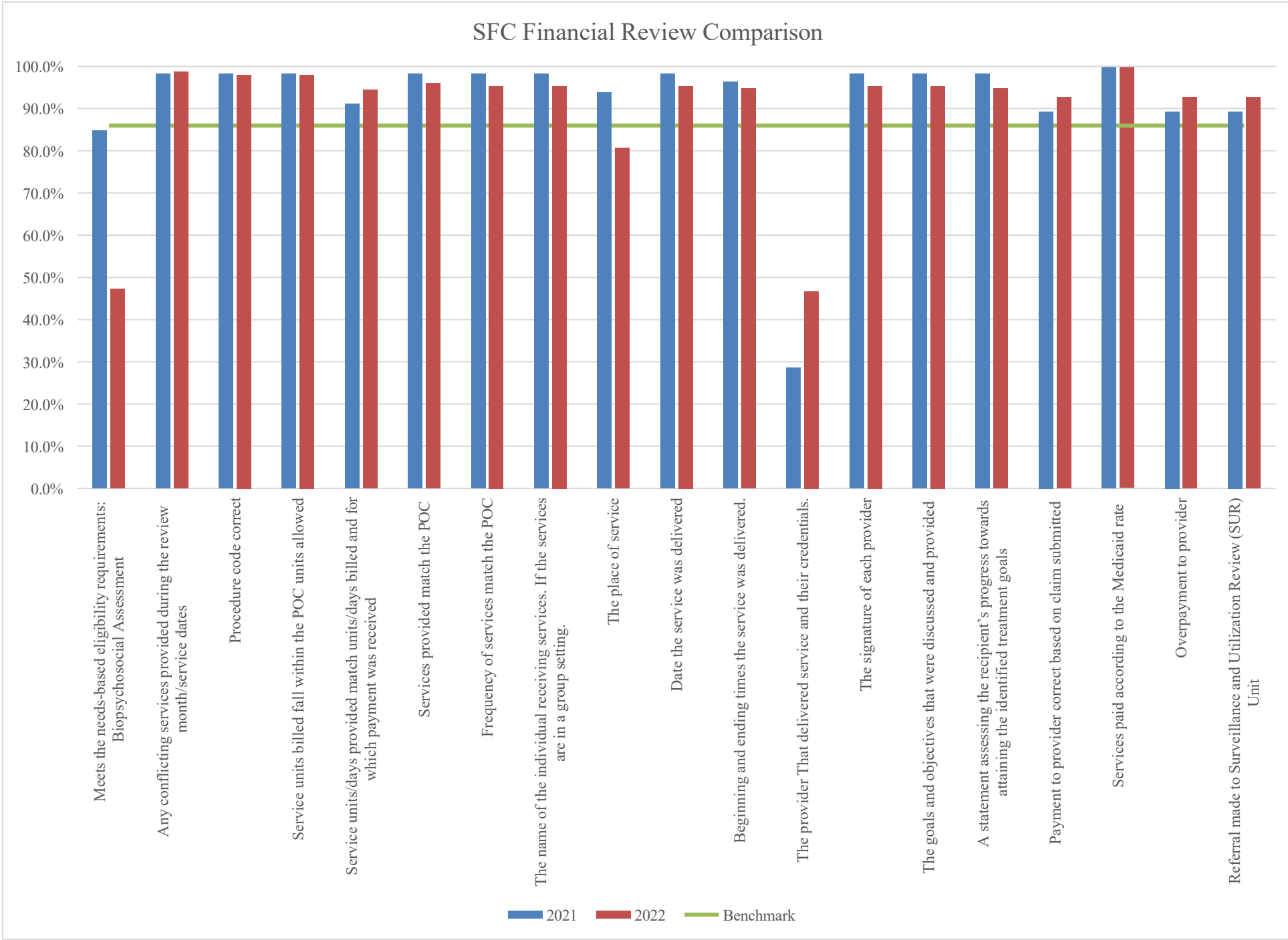
2022 Financial Review Results

Findings identify areas of deficiency discovered through the completion of the Annual Statewide SFC State Plan Review. The following findings are provided as guidance to focus development on building best practices for quality improvement:

Financial Review Results

CMS requires quality improvement projects/remediation when the threshold of compliance is below eighty-six percent (86%). For the 2022 review period, three (3) elements have been identified as needing further analysis.

- Meets the needs-based eligibility requirements: 47%
- The place of service: 81%
- The provider that delivered service and their credentials: 47%


SFC Financial Review Comparison
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Meets the needs-based eligibility requirements: Biopsychosocial Assessment
Any conflicting services provided during the review month/service dates
Procedure code correct
Service units billed fall within the POC units allowed
Service units/days provided match units/days billed and for which payment was received
Services provided match the POC
Frequency of services match the POC
The name of the individual receiving services. If the services are in a group setting.
The place of service
Date the service was delivered
Beginning and ending times the service was delivered.
The provider That delivered service and their credentials.
The signature of each provider
The goals and objectives that were discussed and provided
A statement assessing the recipient's progress towards attaining the identified treatment goals
Payment to provider correct based on claim submitted
Services paid according to the Medicaid rate
Overpayment to provider
Referral made to Surveillance and Utilization Review (SUR) Unit
2021
2022
Benchmark

2021 vs 2022 Financial Review Comparison

For 2022, improvement is noted in six (6) components from the previous 2021 review period. The most notable being in: “Any conflicting services provided during the review month/service dates” at almost ninety-nine percent (99%) seeing an increase of point five percent (0.5%) from the prior reporting year, “Service units/days provided match units/days billed and for which payment was received” at over ninety-four percent (94%) showing an increase of three percent (3%), as well as “The provider that delivered service and their credentials” at almost forty-seven percent (47%) increasing of over eighteen percent (18%) from the previous year. Additionally, two (2) review elements remained at one hundred percent (100%) compliance with one (1) additional element “Services paid according to Medicaid allowable rate” coming into one hundred percent (100%) compliance.

Quality Improvement Project Performance

(Percentages calculated by total number provided over the total number required.)

Requirement 6: Financial Accountability

- The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.
  Review Question 16: Payment to provider correct based on claim submitted.

2020	N/A
2021	89.3%
2022	92.7%

Recommendations & Observations

Recommendations are suggestions to help improve the effectiveness and quality of waiver operations. The following recommendations are provided as guidance to develop best practices for continuing quality improvement:

- In an effort to mitigate errors from 2021 and 2022, Administration and Operations will need to meet to discuss policies in depth and ensure accuracy of requirements align with current practices while being compliant with federal and state guidelines.
- Administration and Operations will hold meetings with county and state supervisors to discuss deficiencies and make remediation plans and trainings when necessary.

Case File Review Requirements

Assurance	NAC/CFR	NAC/CFR	State Plan/CMS	State Plan	MSM/DCFS	MSM Chapter
Eligibility Criteria						
Meets the needs-based eligibility requirements: ***Biopsychosocial Assessment and ECSII or CASII AND At Least 1 Risk Factor***	For each individual determined to be eligible for the State plan HCBS benefit, the State must provide for an independent assessment of needs, which may include the results of a standardized functional needs assessment, in order to establish a service plan. In applying the requirements of section 1915(i)(1)(F) of the Act, the State must: (1) Perform a face-to-face assessment of the individual by an agent who is independent and qualified as defined in § 441.730, and with a person-centered process that meets the requirements of § 441.725(a) and is guided by best practice and research on effective strategies that result in improved health and quality of life outcomes. b) Conflict of interest standards. The State must define conflict of interest standards that ensure the independence of individual and agency agents who conduct (whether as a service or an administrative activity) the independent evaluation of eligibility for State plan HCBS, who are responsible for the independent assessment of need for HCBS, or who are responsible for the development of the service plan. The conflict-of-interest standards apply to all individuals and entities, public or private. At a minimum, these agents must **not** be any of the following: (4) Holding financial interest, as defined in § 411.354 of this chapter, in any entity that is paid to provide care for the individual. (5) Providers of State plan HCBS for	§ 441.720 Independent assessment. (1)(a) § 441.730 Provider qualifications. (b)(4)(5)	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) Child and Adolescent Service Intensity Instrument (CASII) AND 2. Other Community Alternatives: 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	§1915(i) State Plan HCBS SPA, EVALUATION/RE EVALUATION OF ELIGIBILITY, 5. Needs-based HCBS Eligibility Criteria (eff. 07/01/2021) Pg 9 (eff. 03/29/2023) Pg 10	A. Impaired Functioning & Service Intensity: The Care Coordinator and Child and Family Team (CFT) will use a comprehensive biopsychosocial assessment and the level of care decision support tools the ECSII or CASII. The Wraparound Facilitator and CFT will review clinical indicators of impaired functioning: Prior psychological assessment records, prior placement history, and prior treatment history. Youth must demonstrate significant levels of behavioral health needs as evidenced by Serious Emotional Disturbance (SED) determination; and must demonstrate a minimum CASII or ECSII level of 1; and B. Other Community Alternatives: The accessibility and/or intensity of currently available community supports and services are inadequate to meet these needs due to the severity of the impairment without the provision of one or more of the services contained in the HCBS Benefit, as determined by the Division of Child and Family Services (DCFS) or its designee as evidenced by at least one of the following risk factors: 1. At risk of higher level of care placement due to recent placement disruption within the past six months; 2. Current placement in emergency shelter or congregate care due to behavioral and mental health needs; 3. In need of transition to community-based living arrangement with intensive behavioral supports when returning or stepping down from residential treatment center or other higher level of care placement; and/or 4. At risk of higher level of care placement because prior less restrictive placements or interventions, such as traditional family foster care and/or community treatment	MSM Chapter 4000, Section 4003.1 A&B(1-4) Pg 1

	the individual, or those who have an interest in or are employed by a provider of State plan HCBS for the individual, 2.b) The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately. 1915i State Plan HCBS SPA (eff. 07/01/2020) Pg 35 (eff. 03/29/2023) Pg 36 1. Care Coordinator and CFT will use a comprehensive biopsychosocial assessment and the level of care decision support tools the ECSII or CASII. **AND** 2. At least 1 Risk Factor. 1915i State Plan HCBS SPA (eff. 07/01/2020) Pg 9 (eff. 03/29/2023) Pg 10 Reassessments. The independent assessment of need must be conducted at least every 12 months and as needed when the individual's support needs or circumstances change significantly, in order to revise the service plan.	CFR- § 441.720 Independent assessment, (b) (2021)	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.		services, have not been successful.	

Eligibility reevaluation completed every 90 days completed and on basis of individual case.	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 §1915(i) State Plan HCBS SPA, (eff. 07/01/2020) Pg 36 (eff. 03/29/2023) Pg 37		3. The Care Coordinator will use a comprehensive biopsychosocial assessment and the level of care decision support tools, (ECSII) or (CASII). The Care Coordinator will evaluate whether an individual meets the needs-based State plan HCBS eligibility criteria. Re-evaluation occurs every 90 days and on the basis of the individual case. 4. Needs-based eligibility reevaluations are conducted at least every twelve months.	§1915(i) State Plan HCBS SPA, EVALUATION/RE EVALUATION OF ELIGIBILITY, 3. Process for Performing Evaluation/Reevaluation & 4. Reevaluation Schedule (eff. 07/01/2021) Pg 8 (eff. 03/29/2023) Pg 9		
Assurance	**NAC/CFR**	**NAC/CFR**	**State Plan/CMS**	**State Plan/CMS EFF. 07/01/2021**	**MSM/DCFS**	**MSM Chapter**
Plan of Care						
POC provided (service plan/care plan)	(a) Person-centered planning process. Based on the independent assessment required in § 441.720, the State must develop (or approve, if the plan is developed by others) a written service plan jointly with the individual (including, for purposes of this paragraph, the individual and the individual's authorized representative if applicable). The person-centered planning process is driven by the individual.	CFR- § 441.725(a) Person-centered service plan (eff. 08/10/2023)	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). The person-centered POC will include detailed service plans for applicable 1915(i) services. The CFT shall develop the	§1915(i) State Plan HCBS SPA, PERSON-CENTERED PLANNING & SERVICE DELIVERY (2) (eff. 07/01/2021) Pg 15 (eff. 03/29/2023) Pg 16 §1915(i) State Plan HCBS SPA, PERSON-CENTERED PLANNING & SERVICE	The person-centered plan of care is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered plan of care meets federal requirements at 42 CFR §441.725(b). 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 to timeframes as listed in DCFS policy.	MSM Chapter 4000, Section 4003.3 F(1)(b) Pg 4 MSM Chapter 4003.3 f (2)(d) Pg 5

			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.	DELIVERY (5) (eff. 07/01/2021) Pg 17 (eff. 03/29/2023) Pg 18		
POC is Person Centered	The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the individual, and the scope of services and supports available under the State plan HCBS benefit.		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). The Care Coordinator will utilize assessments to create individualized POC for children and families. The person-centered POC will include detailed service plans for applicable 1915(i) services. The CFT shall develop the	§1915(i) State Plan HCBS SPA, PERSON-CENTERED PLANNING & SERVICE DELIVERY (2) (eff. 07/01/2021) Pg 15 (eff. 03/29/2023) Pg 16 Responsibility for Development of Person-Centered Service Plan. (eff. 07/01/2021) Pg 17 (eff. 03/29/2023) Pg 18	The development of the person-centered POC led by the Child and Family Team (CFT) approach will focus on a strengths and needs-driven approach that provides intensive care management in a team.	MSM Chapter 4000, Section 4003.3 F(2)(a) Pg 4

			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 to timeframes as listed in DCFS policy. The Care Coordinator is responsible to submit the developed POC to the QIO-like vendor for approval.			
Q6) POC was specific/ measurable/ achievable			The Care Coordinator will utilize assessments to create 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	§1915(i) State Plan HCBS SPA, PERSON-CENTERED PLANNING & SERVICE DELIVERY, 5. Responsibility for Development of Person-Centered Service Plan (eff. 07/01/2021) Pg 17 (eff. 03/29/2023) Pg 18	The Care Coordinator will utilize assessments to create a person-centered POC for children and families. The plan will include needs, outcomes, and strategies that are: 1. Specific. The CFT, including the family, should know exactly what must be completed or changed and why. 2. Measurable. Everyone should know when the needs have been met. Outcomes will be measurable to the extent that they are behaviorally based and written in clear and understandable language. 3. Achievable. The CFT and family should be able to meet the identified needs in a designated time period given the resources that are accessible and available to support change.	MSM Chapter 4000, Section 4003.3 F(2)(c)(1-3) Pg 5

			period given the resources that are accessible and available to support change.			
POC address assessed needs.	1.a) Service plans address assessed needs of 1915(i) participants. §1915i State Plan HCBS SPA (eff. 07/01/2021) Pg 29 (eff. 03/29/2023) Pg 30		Plan of Care a) address assessed needs of 1915(i) participants	§1915(i) State Plan HCBS SPA, QUALITY IMPROVEMENT STRATEGY, Quality Measures (1)(a) (eff. 07/01/2021) Pg 29 (eff. 03/29/2023) Pg 30	The person-centered POC will include detailed service plans for applicable 1915(i) services.	MSM Chapter 4000, Section 4003.3 F(2)(d) Pg 5
POC created within 45 days of removal or the Agency's decision to provide in-home services.			The Care Coordinator will utilize assessments to create individualized POC for children and families. 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 to timeframes as listed in DCFS policy. The Care Coordinator is responsible to submit the developed POC to the QIO-like vendor for approval.	§1915(i) State Plan HCBS SPA, PERSON-CENTERED PLANNING & SERVICE DELIVERY Responsibility for Development of Person-Centered Service Plan. (eff. 07/01/2021) Pg 17 (eff. 03/29/2023) Pg 18	Prepare a Case Plan no later than forty-five (45) calendar days following removal or decision to provide ongoing services. Update the case plan when the decision to adjust permanency goal(s) or add a concurrent goal within five (5) business days of the decision. (eff. 06/09/2022)	MTL # 0204 – 6162022 Pg 12

POC reevaluated every 90 days (thru 06/08/22) **POC reevaluated every 6 months (effective 06/09/22)**			The Care Coordinator in collaboration with the team shall reevaluate the POC at least every 90 days with readmission of DCFS approved assessments as appropriate. The Care Coordinator will also be responsible for documenting updates to the POC, including recommendations and decisions made by the CFT, in accordance to timeframes as listed in DCFS policy. The Care Coordinator is responsible to submit the developed POC to the QIO-like vendor for approval.	§1915(i) State Plan HCBS SPA, PERSON-CENTERED PLANNING & SERVICE DELIVERY, 7. Informed Choice of Providers (eff. 07/01/2021) Pg 19 (eff. 03/29/2023) Pg 20 §1915(i) State Plan HCBS SPA, PERSON-CENTERED PLANNING & SERVICE DELIVERY Responsibility for Development of Person-Centered Service Plan. (eff. 07/01/2021) Pg 17 (eff. 03/29/2023) Pg 18	The person-centered plan of care is reviewed and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly and at the request of the individual. The frequency that a case plan must be updated was changed from every 90 days to every 6 months. (effective 06/09/2022)	MSM Chapter 4000, Section 4003.3F(1)(c) Pg 4 MTL # 0204 – 6162022 Pg 1

POC updated annually or more frequently as needed.	1.b) Service plans are updated annually. §1915i State Plan HCBS SPA (effective 07/01/2020 Pg 30) (effective 03/29/2023 Pg 31)		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. Meet at least every 30 days to coordinate the implementation of the POC and update the POC as necessary.	§1915(i) State Plan HCBS SPA, PERSON-CENTERED PLANNING & SERVICE DELIVERY (3) (eff. 07/01/2021) Pg 15 (eff. 03/29/2023) Pg 16 §1915(i) State Plan HCBS SPA, QUALITY IMPROVEMENT STRATEGY, Quality Measures (1)(b) (eff. 07/01/2021) Pg 29 (eff. 03/29/2023) Pg 30 §1915(i) State Plan HCBS SPA, PERSON-CENTERED PLANNING & SERVICE DELIVERY, 6. Supporting the Participant in Development of Person-Centered Service Plan (eff. 07/01/2021) Pg 18-19 (eff. 03/29/2023) Pg 19-20	The person-centered plan of care is reviewed and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly and at the request of the individual.	MSM Chapter 4000, Section 4003.3 F(1)(c) Pg 4
Amount/Frequency/Duration for each service.			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	§1915(i) State Plan HCBS SPA, INTENSIVE IN-HOME SUPPORTS AND SERVICES, Categorically Needy (eff. 07/01/2020) Pg 22 (eff. 03/29/2023) Pg 23	The amount, frequency and duration of this service is based on participant's assessed needs and document in the approved POC.	MSM Chapter 4000, Section 4003.4A(1) Pg 7

			requirements.			
POC signed by CFT members, caregiver/ guardian, child/youth (if over 12 years old) and Care Coordinator.			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.	§1915(i) State Plan HCBS SPA, PERSON-CENTERED PLANNING & SERVICE DELIVERY, 7. Informed Choice of Providers (eff. 07/01/2021) Pg 19 (eff.03/29/2023) Pg 20	The CFT Facilitator shall be responsible for gaining necessary signatures on the Case Plan per Case Plan.	DIVISION OF CHILD AND FAMILY SERVICES/JJS 500.02 VIII(A) (eff. 02/21/2022)
POC documents choice of services and providers.	1.c) Service plans document choice of services and providers. §1915i State Plan HCBS SPA (effective 07/01/2020 Pg 31) (effective 03/29/2023 Pg 32)		Plan of Care c) document choice of services and providers.	§1915(i) State Plan HCBS SPA, QUALITY IMPROVEMENT STRATEGY, Quality Measures (1)(c) (eff. 07/01/2020) Pg 29 (eff. 03/29/2023) Pg 30		

Financial Review Requirements

Assurance	Sub-Requirement	NAC/CFR	State Plan/CMS	State Plan	MSM/DCFS	MSM Chapter
Financial						
Meets the needs-based eligibility requirements: Biopsychosocial Assessment ESSII or CASII/SED AND At Least 1 Risk Factor (Checklist is sufficient)	QUALITY IMPROVEMENT STRATEGY (7)(6) The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers. 1915i State Plan HCBS SPA (eff. 07/01/2021) Pg 39 (eff. 03/29/2023) Pg 40	Reassessments. The independent assessment of need must be conducted at least every 12 months and as needed when the individual's support needs or circumstances change significantly, in order to revise the service plan.	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) Child and Adolescent Service Intensity Instrument (CASII) AND 2. Other Community Alternatives: 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	§1915(i) State Plan HCBS SPA, EVALUATION/REEVALUATION OF ELIGIBILITY, 5. Needs-based HCBS Eligibility Criteria (eff. 07/01/2021) Pg 9 (eff. 03/29/2023) Pg 10	Requirement for all services to be prior authorized to be eligible for reimbursement. A. Impaired Functioning & Service Intensity: The Care Coordinator and Child and Family Team (CFT) will use a comprehensive biopsychosocial assessment and the level of care decision support tools the ECSII or CASII. The Wraparound Facilitator and CFT will review clinical indicators of impaired functioning: Prior psychological assessment records, prior placement history, and prior treatment history. Youth must demonstrate significant levels of behavioral health needs as evidenced by Serious Emotional Disturbance (SED) determination; and must demonstrate a minimum CASII or ECSII level of 1; and B. Other Community Alternatives: The accessibility and/or intensity of currently available community supports and services are inadequate to meet these needs due to the severity of the impairment without the provision of one or more of the services contained in the HCBS Benefit, as determined by the Division of Child and Family Services (DCFS) or its designee as evidenced by at least one of the following risk factors: 1. At risk of higher level of care placement due to recent placement disruption within the past six months; 2. Current placement in emergency shelter or congregate care due to behavioral and mental health needs; 3. In need of transition to community-based living arrangement with intensive behavioral supports when returning or stepping down from residential treatment center or other higher level of care placement; and/or 4. At risk of higher level of care placement	MSM 3303.3A(2)(l)(2) (eff. 05/01/2019) MSM 4003.1 (eff. 10/27/2021)

			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.		because prior less restrictive placements or interventions, such as traditional family foster care and/or community treatment services, have not been successful.	
Any conflicting services provided during the review month/service dates (IIHS: cannot be reimbursed if billed on the same date of service as Psychosocial Rehabilitation (PSR) and Basic Skills Training (BST))					Intensive In-Home services cannot be reimbursed if billed on the same date of service as Psychosocial Rehabilitation (PSR) and Basic Skills Training (BST).	MSM 4003.4A IIHS (eff. 10/27/2021)
Procedure code correct					Improper payments include but are not limited to: payments where the incorrect procedure code was billed (up-coding). Claim billed with incorrect procedure code.	MSM 3302.4 Improper payment 3303.2A(4)(a)(1)(b) (eff. 05/01/2019)
Service units billed fall within the POC units allowed: **a. IIHS: Maximum of 2 hours per day, 7 days a week** **b. CSS: 4 hours for up to 40 hours per month**					Improper payments include but are not limited to: payments where an incorrect number of units were billed. The number of units billed was incorrect. 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	MSM 3302.4 Improper payment, MSM 3303.2A (4)(a)(1)(d) (eff. 05/01/2019) IIHS: MSM 4003.4A(1)(b)

(additional units may be authorized)					fidelity. Maximum of one hour per week. The maximum number of service hours per day is four hours for up to 40 hours per month. Post authorization request is required beyond 40 hours. Additional units of services may be authorized by the DHCFP or designee on post authorization review.	CSS: MSM 4003.5A(4)
Service units/days provided match units/days billed and for which payment was received					Submitting a bill for a service not provided. The DHCFP policy and the DHCFP provider agreement to cooperate and provide any and all documentation (e.g., medical records, charts, billing information and any other documentation) requested by the DHCFP or other state and/or federal officials or their authorized agents for the purpose of determining the validity of claims and the reasonableness and necessity of all services billed to and paid by the DHCFP.	MSM 3303.1A(2)(x)(2) (eff. 10/27/2021) MSM 3303.2B(1) (eff. 10/27/2021)
Services provided match the POC					Improper payments include but are not limited to: payments for services that were not provided or received.	MSM 3302.4 Improper payment (eff. 05/01/2019)
Frequency of services match the POC					All progress notes documented with the intent of submitting a billable Medicaid behavioral health service claim must be documented in a manner that is sufficient to support the claim and billing of the services provided and must further document the amount, scope, and duration of the service(s) provided as well as identify the provider of the service(s).	MSM 4003.3(F)(3)(a) (eff. 10/27/2021)
The name of the individual receiving services. If the services are in a group setting					The name of the individual receiving the service(s). If the services are in a group setting, it must be indicated.	MSM 4003.3(F)(3)(b)(1) (eff. 10/27/2021)
The place of service					The place of service.	MSM 4003.3(F)(3)(b)(2) (eff. 10/27/2021)
Date the service was					The date the service was delivered.	MSM 4003.3(F)(3)(b)(3) (eff. 10/27/2021)

delivered						
Beginning and ending times the service was delivered.					The actual beginning and ending times the service was delivered.	MSM 4003.3(F)(3)(b)(4) (eff. 10/27/2021)
The provider what delivered service and their credentials.					The name of the provider who delivered the service. If credentialed, the credentials of the person who delivered the Service.	MSM 4003.3(F)(3)(b)(5,6) (eff. 10/27/2021)
The signature of the provider					The signature of the provider who delivered the service.	MSM 4003.3(F)(3)(b)(7) (eff. 10/27/2021)
The goals and objectives that were discussed and provided					The goals and objectives that were discussed and provided during the time the services were provided.	MSM 4003.3(F)(3)(b)(8) (eff. 10/27/2021)
A statement assessing the recipient's progress towards attaining the identified treatment goals					A statement assessing the recipient's progress towards attaining the identified treatment goals and objectives requested by the treatment team.	MSM 4003.3(F)(3)(b)(9) (eff. 10/27/2021)
Payment to provider correct based on claim submitted					Improper payments include but are not limited to: payments that cannot be substantiated by appropriate or sufficient medical or service record documentation.	MSM 3302.4 Improper payment (eff. 05/01/2019)
Services paid according to the Medicaid rate					Improper payments include but are not limited to: Payments where the incorrect procedure code was billed (up-coding); payments over Medicaid allowable amounts.	MSM 3303.2B(4) (eff. 05/01/2019)
Overpayment to provider					Improper payments include but are not limited to: An improper payment can be an overpayment or an underpayment. This is an amount paid by the DHCFP, to a provider, which is in excess of or less than the amount that is allowable for services furnished under applicable policy, rate or regulation.	MSM 3302.4 Improper payment MSM 3302.6 (eff. 05/01/2019)
Referral made					Administering Agency QA will provide	SPA Quality

to Surveillance and Utilization Review (SUR) Unit					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.	Improvement Strategy 6. (eff. 0/01/2020 & 03/29/2023)
Provider eligible for payment (active) at time-of-service provision					All providers must verify each month continued Medicaid eligibility for each recipient. This can be accomplished by utilizing the electronic verification system (EVS) or contacting the eligibility staff at the welfare office hotline. Verification of Medicaid eligibility is the sole responsibility of the provider.	MSM 4003.3(B)

Acronyms & Definitions 1915(i) ADHC & HBHS

ADL- (ACTIVITIES OF DAILY LIVING)
Self-care activities routinely performed daily, such as bathing, dressing, grooming, toileting, transferring, mobility, continence and eating.

AFC- (ADVANCED FOSTER CARE)
A "specialized" or "advanced" version of foster care in which foster parents are provided with additional training and support in order to provide specialized care and support to high- needs youth.

ARPA- (AMERICAN RESCUE PLAN ACT)
The American Rescue Plan Act of 2021 is a $1.9 trillion economic stimulus bill passed by Congress and signed by President Biden in March 2021. The bill aims to provide relief to individuals, businesses, state and local governments, and public health agencies affected by the COVID-19 pandemic.

BH- (BEHAVIORAL HEALTH)
Behavioral health generally refers to mental health and substance use disorders, life stressors and crises, and stress-related physical symptoms. Behavioral health care refers to the prevention, diagnosis and treatment of those conditions.

CASII- (CHILD AND ADOLESCENT SERVICE INTENSITY INSTRUMENT (youth ages 6-18))
A standardized assessment tool that provides a determination of the appropriate level of services needed by a child or adolescent and his or her family.

CC- (CARE COORDINATOR)
A care coordinator is a specialized social worker and healthcare professional who oversees and coordinates the continued care of clinical patients. They often work with patients with long-term or chronic illnesses, ensuring that these patients receive effective care.

CFR- (CODE OF FEDERAL REGULATIONS)
The CFR is a codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the Federal government. The Code is divided into 50 titles which represent broad areas subject to federal regulation.

CM- (CASE MANAGEMENT)
Case management is a process by which an individual's needs are identified and social and medical services to meet those needs are located, coordinated, and monitored. Case management may be targeted to certain populations in certain areas of the state under the authority of Section 1905(a)(19) of the Social Security Act

CMS- (CENTERS FOR MEDICARE AND MEDICAID SERVICES)
The Federal government entity that monitors state programs to assure minimum levels of public health service are provided, as mandated in the 42 CFR.

CPC- (CLINICAL PROFESSIONAL COUNSELOR)
Works with individuals, families or groups on a number of mental health issues. This can mean anything from diagnosing depression to treating substance abuse problems. People may seek the help of a licensed professional clinical counselor when they feel that their life is spinning out of control. Perhaps childhood sexual abuse has led them to make unwise life decisions or maybe they are dealing with thoughts of suicide. It is the role of the LPC to get to the root of these issues and to help the individual develop more effective coping strategies**.**

CSS- (CRISIS STABILIZATION SERIVES)
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 pertaining to following a crisis.

CW- (CASE WORKERS)
A person concerned with individuals, especially that involving a study of a person's family history and personal circumstances.

DC 0-3- (DIAGNOSTIC CLASSIFICATION OF MENTAL HEALTH AND DEVELOPMENTAL DISORDERS OF INFANCY AND EARLY CHILDHOOD DIAGNOSIS)
Published in 1994 by ZERO TO THREE, was created to address the significant need for a systematic, developmentally based approach to the classification of mental health and developmental difficulties in the first 4 years of life (i.e., birth through 3 years old).

DCFS- (DIVISION OF CHILD AND FAMILY SERVICES)
The Nevada Division of Child and Family Services (DCFS), together in genuine partnership with families, communities and other governmental agencies, provides support and services to assist Nevada's children and families in reaching their full human potential.

DHCFP- (DIVISION OF HEALTH CARE FINANCING AND POLICY)
Works in partnership with the Centers for Medicare & Medicaid Services to assist in providing quality medical care for eligible individuals and families with low incomes and limited resources. Services are provided through a combination of traditional fee-for-service provider networks and managed care.

DMCT- (NEVADA DESIGNATED MOBILE CRISIS TEAM)
Provides crisis intervention and short-term support to Nevada families dealing with a behavioral or mental health crisis. MCRT provides short-term counseling and case management until they can connect families with long-term providers and peer support.

DSM-5- (DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS)
A reference book, published by The American Psychiatric Association (APA), on mental health and brain-related conditions and disorders.

DSS- (DECISION SUPPORT SYSTEM)
Database of Medicaid recipients and providers utilized by DHCFP QA for recipient selection for the review year as well as financial claims.

ECSII- (EARLY CHILDHOOD SERVICE INTENSITY INSTRUMENT (youth ages 0-5))
Determines intensity of service needed for infants, toddlers, and children from ages 0-5 years. The ECSII is a tool for providers and others involved in the care of young children with emotional, behavioral, and/or developmental needs, and their families, including those children who are experiencing environmental stressors that may put them at risk for such problems.

FAC- (FISCAL AGENT CONTRACTOR)
A fiscal agent is an organization, such as a bank or trust company, that acts on behalf of another party performing various financial duties.

FFP- (FEDERAL FINANCIAL PARTICIPATION)
The portion paid by the federal government to states for their share of expenditures for providing Medicaid services and for administering the Medicaid program and certain other human service programs. Also called federal medical assistance percentage (FMAP).

GDN- (GUARDIAN)
Someone appointed by the court to manage the personal and financial affairs of another person.

HA- (HEALTH ASSESSMENT)
Health assessment is the evaluation of the health status by performing a physical exam after taking a health history.

HBHS- (HOME BASE HABILITATION SERVICES)
Home base habilitation services (HBHS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community. These programs serve a variety of targeted populations groups, such as people with mental illnesses, intellectual or developmental disabilities, and/or physical disabilities.

HCBS- (HOME AND COMMUNITY-BASED SERVICES)
Home and community-based services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community. These programs serve a variety of targeted populations groups, such as people with mental illnesses, intellectual or developmental disabilities, and/or physical disabilities.

HCQC- (HEALTH CARE QUALITY COMPLIANCE)
The Bureau of Health Care Quality and Compliance (HCQC) licenses the following health facility types in Nevada.

HIPAA- (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996)
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge.

HHS- (HEALTH AND HUMAN SERVICES)
The United States Department of Health and Human Services is a cabinet-level executive branch department of the U.S. federal government created to protect the health of all Americans and providing essential human services.

IA- (INITIAL ASSESSMENT)
This assessment is conducted as an administrative function of the waiver program and evaluates service needs based on functional deficits, support systems and imminent risk of institutionalization.

IADL- (INSTRUMENTAL ACTIVITIES OF DAILY LIVING)
Activities related to independent living including preparing meals, shopping for groceries or personal items, performing light or heavy housework, communication, and money management.

ICD- (INTERNATIONAL CLASSIFICATION DISEASE)
ICD serves a broad range of uses globally and provides critical knowledge on the extent, causes and consequences of human disease and death worldwide via data that is reported and coded with the ICD.

ID- (INTELLECTUAL DISABILITY)
A disability characterized by significant limitations both in intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills. This disability originates before the age of 18.

IDEA- (INDIVIDUALS WITH DISABILITIES EDUCATION IMPROVEMENT ACT)
A law that makes available a free appropriate public education to eligible children with disabilities throughout the nation and ensures special education and related services to those children.

IIHS- (INTENSIVE IN-HOME SUPPORTS AND SERVICES)

Evidence-based interventions that target emotional, cognitive and behavioral functioning within a variety of actual and/or simulated social settings.

LCSW- (LICENSED CLINICAL SOCIAL WORKER)
A specialty practice area of social work which focuses on the assessment, diagnosis, treatment, and prevention of mental illness, emotional, and other behavioral disturbances.

LMFT- (LICENSED MARRIAGE AND FAMILY THERAPIST)
Mental health professionals trained in psychotherapy and family systems and licensed to diagnose and treat mental and emotional disorders within the context of marriage, couples and family systems.

MCO- (MANAGED CARE ORGANIZATION)
Nevada Medicaid works closely with the MCOs, DBA, and the Division of Welfare and Supportive Services (DWSS) to ensure recipients in the MCO and DBA covered areas are informed and supported as they seek medical and dental care.

MD- (MEDICAL DOCTOR)
A licensed medical practitioner.

MFCU- (MEDICAID FRAUD CONTROL UNIT)
Medicaid Fraud Control Units (MFCUs) investigate and prosecute Medicaid provider fraud as well as abuse or neglect of residents in health care facilities and board and care facilities and of Medicaid beneficiaries in noninstitutional or other settings.

MMIS- (MEDICAID MANAGEMENT INFORMATION SYSTEM)
A computer system designed to help managers plan and direct business and organizational operations.

MSM- (MEDICAID SERVICES MANUAL)
The policies that govern Medicaid services.

NAC- (NEVADA ADMINISTRATIVE CODE)
The Nevada Administrative Code (NAC) is the codified administrative regulations of the Executive Branch. The Nevada Register is a compilation of proposed, adopted, emergency and temporary administrative regulations, notices of intent and informational statements.

NMO- (NEVADA MEDICAID OFFICE)
The Nevada Medicaid Office is responsible for policy, planning and administration of the Nevada Medicaid program; also known as the Division of Health Care Financing and Policy.

NPI- (NATIONAL PROVIDER IDENTIFIER)
The NPI is a unique identification number for covered health care providers.

NRS- (NEVADA REVISED STATUES)
A compilation of all the current state laws in Nevada.

PA- (PRIOR AUTHORIZATION)
Prior Authorization Request Nevada Medicaid and Nevada Check Up Adult Day Health Care (ADHC) request prior authorization for ADHC services through the Nevada Medicaid program.

PCA- (PERSONAL CARE ASSISTANT)
Personal care assistants, also known as caregivers, home health or personal care aides, give assistance to people who are sick, injured, mentally or physically disabled, or the elderly and fragile.

PCP- (PERSON CENTERED PLANNING)
An assessment and service planning process are directed and led by the individual, with assistance as needed or desired from representatives or other persons of the individual's choosing. The process is designed to identify the strengths, capacities, preferences, needs and desired outcomes of the individual. The process may include other people, freely chosen by the individual, who are able to serve as important contributors to the process. The PCP process enables and assists the individual to identify and access a personalized mix of paid and non-paid services and supports that assist him/her to achieve personally defined outcomes in the community.

PEU- (DCFS CHILDREN'S MENTAL HEALTH PLANNING AND EVALUATION UNIT)
Provide a standard of excellence in programs and service delivery for all children's mental health clients and their families.

PIHP- (PREPAID AMBULATORY HEALTH PLAN)
An entity that provides medical services to enrollees under contract with the state agency, and since prepaid capitation payments, or other payment arrangements that do not use state plan payment rates; does not provide or arrange for and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and does not have a comprehensive risk contract.

POC- (PLAN OF CORRECTION)
A provider's plan for how and when it will correct Federal deficiencies and/or state violations.

P&P- (POLICY & PROCEDURE)
A transmittal issued on policies adopted by the DHCFP to provide clarification and guidance within the boundaries of that policy.

QA- (QUALITY ASSURANCE)
A structured, internal monitoring and evaluation process designed to improve quality of care. QA involves the identification of quality of care criteria, which establishes the indicators for program measurements and corrective actions to remedy any deficiencies identified in the quality of direct patient, administrative and support services.

QI- (QUALITY IMPROVEMENT)
A critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

QIO- (QUALITY IMPROVEMENT ORGANIZATIONS)
A Quality Improvement Organization (QIO) is a group of health quality experts, clinicians, and consumers organized to improve the quality of care delivered to people with Medicare.

QIS- (QUALITY IMPROVEMENT STRATEGY)
It provides a framework and tools to plan, organize, and then to monitor, sustain, and spread the changes that data show are improvements.

QMHA- (QUALIFIED MENTAL HEALTH ASSOCIATE)
An individual delivering services under the direct supervision of a QMHP who meets the minimum qualifications.

QMHP- (QUALIFIED MENTAL HEALTH PROFESSIONAL)
A licensed medical practitioner or any other person meeting the qualifications.

RN- (REGISTERED NURSE)
A nurse who has graduated from a college's nursing program or from a school of nursing and has passed a national licensing exam.

RMH- (REHABILIATIVE MENTAL HEALTH)
Mental health services that are rehabilitative and enable the member to develop and enhance psychiatric stability, social competencies, personal and emotional adjustment, and independent living and community skills when these abilities are impaired by the symptoms of mental illness.

SA- (SOCIAL ASSESSMENT)
An assessment that is annually reviewed that addresses the recipient's activities of daily living (ADLs), which are self-care activities, such as bathing, dressing, grooming, transferring, toileting, ambulation, and eating. Instrumental activities of daily living (IADLs), which capture more complex life activities, are also assessed, including meal preparation, light housework, laundry, and essential shopping. In addition, this assessment includes information regarding the recipient's medical history and social needs. The assessment includes risk factors, back-up plans, equipment needs, behavioral status, current support system and unmet service needs.

SAFE- (SAFETY ASSESSMENT FAMILY EVALUATION)
A home-study report ordered by the government, and conducted by home assessors, in cases where a family is applying for kinship, adoption, foster parenting, or private guardianship.

SED- (SEVERE EMOTIONAL DISTURBANCE)
Are persons who are under the age of 18, who have had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-V, that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school or community activities.

SFCP- (SPECIALIZED FOSTER CARE PROGRAM)
Provides intensive in-home supports and services and/or crisis stabilization services to participants and family/caregivers.

SMA- (STATE MEDICAID AGENCY)
Medicaid agency or agency means the single State agency administering or supervising the administration of a State Medicaid plan.

SOC- (STATEMENT OF CHOICE)
A form given to all applicants describing the services offered under the waiver during the intake process. The assigned Service Coordinator informs the applicant of their choice between waiver services and placement in an ICF/ID, in addition to their choice of qualified providers.

SOR- (SERIOUS OCCURRENCE REPORT)
A report of any actual or alleged event or situation involving either the provider/employee or recipient that relates a substantial or serious harm to the safety or wellbeing of the provider/employee or recipient. Serious occurrences may include, but are not limited to the following: suspected physical or verbal abuse, unplanned hospitalization, neglect of the recipient, exploitation, sexual harassment or sexual abuse, injuries requiring medical intervention, an unsafe working environment, any event which is reported to Child or Elder Protective Services or law enforcement agencies, death of the recipient

during the provision of waiver services (PCS),
or loss of contact with the recipient for three consecutive scheduled days.

SPA- (STATE PLAN AMENDMENT)
A Medicaid and 1915(i) state plan is an agreement between a state and the Federal government describing how that state administers its Medicaid and 1915(i) programs. It gives an assurance that a state will abide by Federal rules and may claim Federal matching funds for its program activities.

SSA- (US SOCIAL SECURITY ACT)
Is a law that created the Social Security program as well as insurance against unemployment.

SUR- (SURVEILLANCE AND UTILIZATION REVIEW)
A statewide program that safeguards against unnecessary or inappropriate use of services by preventing excess payments in the Nevada Medicaid and Nevada Check Up programs. The SUR unit analyzes claims data to identify potential fraud, waste, overutilization and abuse; collects provider overpayments and refers appropriate cases to the Medicaid Fraud Control Unit (MFCU) for criminal investigation and prosecution.

WF- (WRAPAROUND FACILITATORS)
A person who guides the wraparound process, which is a collaborative and individualized approach to support people with complex needs.

WCHSA (HAS)- (WASHOE COUNTY HUMAN SERVICES AGENCY)
Promotes the health, safety and well-being of children, adults and seniors who are vulnerable to abuse, neglect and exploitation in Washoe County Nevada.

YLS/CMI- (YOUTH LEVEL OF SERVICE/CASE MANAGEMENT INVENTORY)
Is an assessment instrument used by juvenile justice professionals to measure juvenile offenders' "risks and needs" with regard to various criminogenic factors, such as offense history, family circumstances, educational/vocational skills or deficiencies, substance abuse, etc.