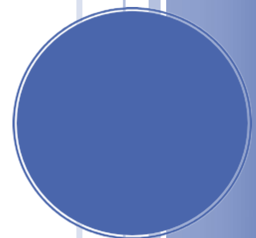
ANNUAL STATEWIDE 1915(i) HOME AND COMMUNITY BASED SERVICES (HCBS) STATE PLAN INTENSIVE IN-HOME SUPPORTS AND SERVICES AND CRISIS STABILIZATION SERVICES, SPECIALIZED FOSTER CARE (SFC) REVIEW FINAL REPORT

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
September 2024
Review Year: State Plan Year (SPY) 4



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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 benefits to determine whether the state requirements are met. The assessment also informs CMS in its review of the state's request to renew 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 **s**tate 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 unnecessary.

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 meets 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:

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?).

1. The performance measure has face validity (i.e., Does the performance measure truly measure the requirement?).
2. 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.
3. The performance measure data is based on a representative sample of the population. CMS approved reducing the number of 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 to make estimates for the population as a whole.
4. The performance measure must provide data specific to the state plan benefit undergoing evaluation.
5. The performance measure data demonstrates the degree of compliance for each data collection period.
6. 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, Access and Availability (QAA) 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. 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 Quality Assurance (QA) reviewers and Operating Agency, Division of Child and Family Services (DCFS), staff will evaluate. The total number of reviews is split between DHCFP QA and DCFS. The ten percent (10%) sample size is also used to determine the required number of financial reviews DHCFP QA will need to complete for each state plan year. Financial reviews were conducted during the months of May and June 2024, covering a one (1) random month sample within the one (1) year look-back.

The annual review period for the HCBS SFC State Plan Year (SPY) four (4) covered July 1, 2023, through June 30, 2024. The ten percent (10%) review requirement determined a sample size of sixty-six (66) reviews, thirty-three (33) reviews completed by DHCFP QA reviewers, and the remaining thirty-three (33) completed by the Operating Agency, DCFS. Out of the sixty-six (66) recipient reviews DHCFP QA reviewed, sixty-three (63) recipient's claims, as three (3) had no billed claims, which resulted in one hundred sixty-one (161) financial claims.

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. Claim
2. Progress Notes
3. 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:

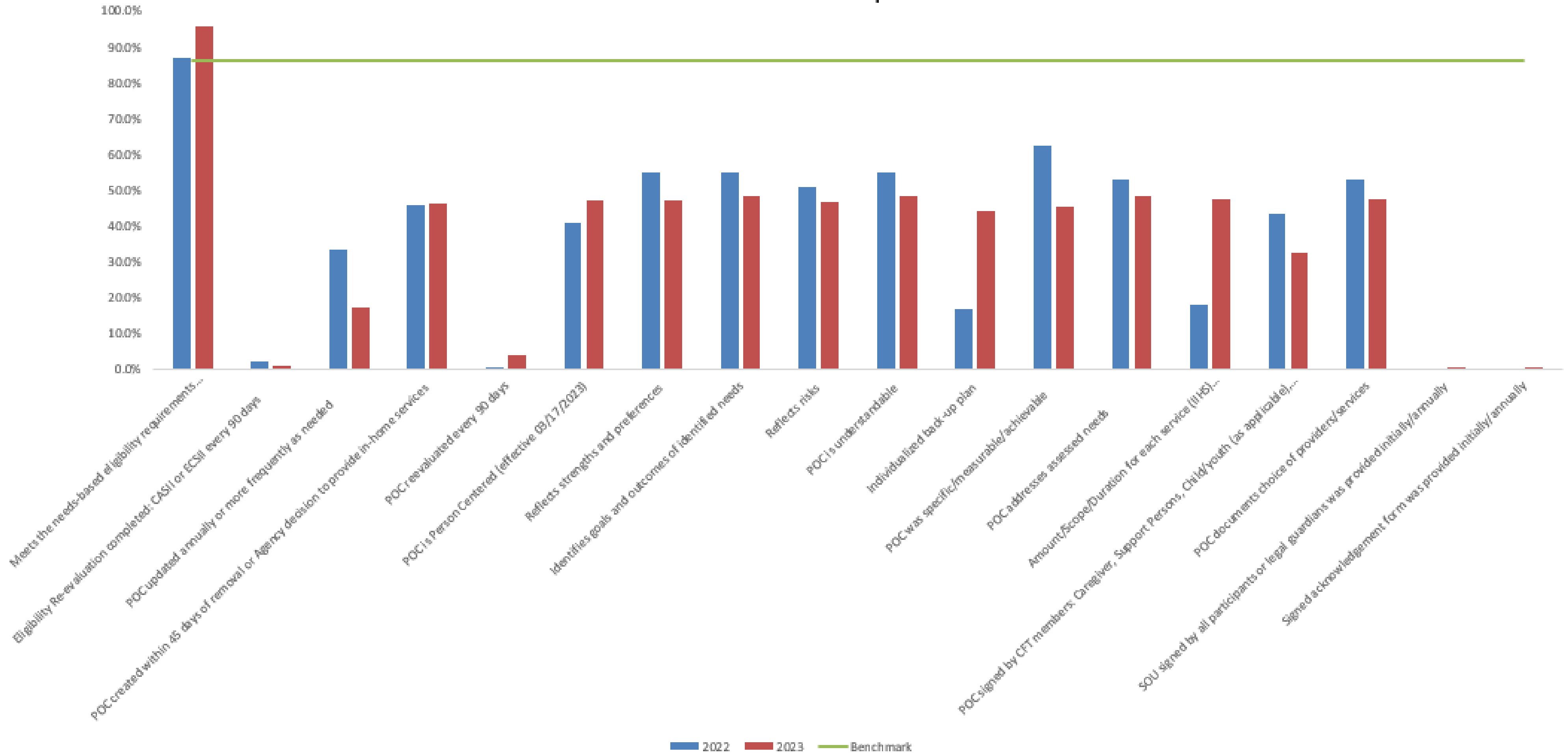
- ❖ MSM Chapter 4000 HCBS State Plan Option Intensive In-Home Services (IIHS) and Crisis Stabilization (CS) (Effective 10/27/2021)
- ❖ MSM Chapter 3300 Program Integrity (Effective 05/01/2019)
- ❖ State Plan: 1915(i) HCBS State Plan Services (Amended effective 07/01/2021, and amended effective 03/29/2023)
- ❖ 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.

SPY 4 (2023) Case File Review Results

ELIGIBLITY	
Contact made within 72 hours of enrollment to schedule face-to-face. (Per SPA Initially)	37.4%
Meets the needs-based eligibility requirements Biopsychosocial Assessment (ESSII or CASII/SED) AND at Least 1 Risk Factor	95.5%
Eligibility Re-evaluation completed: CASII or ECSII every 90 days	1.1%
SFC PLAN OF CARE (POC)	
POC updated annually or more frequently as needed	17.3%
POC created within 45 days of removal or Agency decision to provide in-home services	46.1%
POC re-evaluated every 90 days	3.6%
POC is Person Centered	47.0%
a. Reflects strength and preferences	46.8%
b. Identifies goals and outcomes of identified needs	48.4%
c. Reflects risks	46.7%
d. POC is understandable	48.4%
e. Reflect individualized back-up plan	44.0%
POC was specific/measurable/achievable	45.5%
POC addresses assessed needs	48.4%
Amount/Scope/Duration for each service (IIHS) Amount/Frequency/Duration for each service (CSS)	47.3%
POC signed by CFT members: Caregiver, Support Persons, Child/youth (as applicable), Care Coordinator and Service Provider	32.6%
POC documents choice of providers/services	47.3%
FORMS	
SOU signed by all participants or legal guardians was provided initially/annually	0.5%
Signed acknowledgement form was provided initially/annually	0.5%
MONTHLY MONITORING	
Home visits (IIHS only), Monthly Monitoring (both IIHS and CS)	83.5%
Strengths identified/updated	43.8%
Goals/Outcomes identified/updated	43.7%
Needs/Services identified/updated	51.2%
Crisis Plan reviewed	5.9%
Mission Statement reviewed	5.0%

SFC SPY 3 (2022) and SPY 4 (2023) Case File Review Chart Comparison



SPY 4 (2023) Case File Review Findings

Findings identify areas of deficiency discovered through the completion of the Annual Statewide SFC State Plan Review. CMS requires quality improvement projects/remediation when the compliance threshold is below eighty-six percent (86%). For the SPY 4, 2023 review period, only one (1) element has been identified as being in compliance:

- Meets the needs-based eligibility requirements: 95.5%

All other areas were under tolerance and are detailed out within Project Performance on page 13.

Observations and Recommendations:

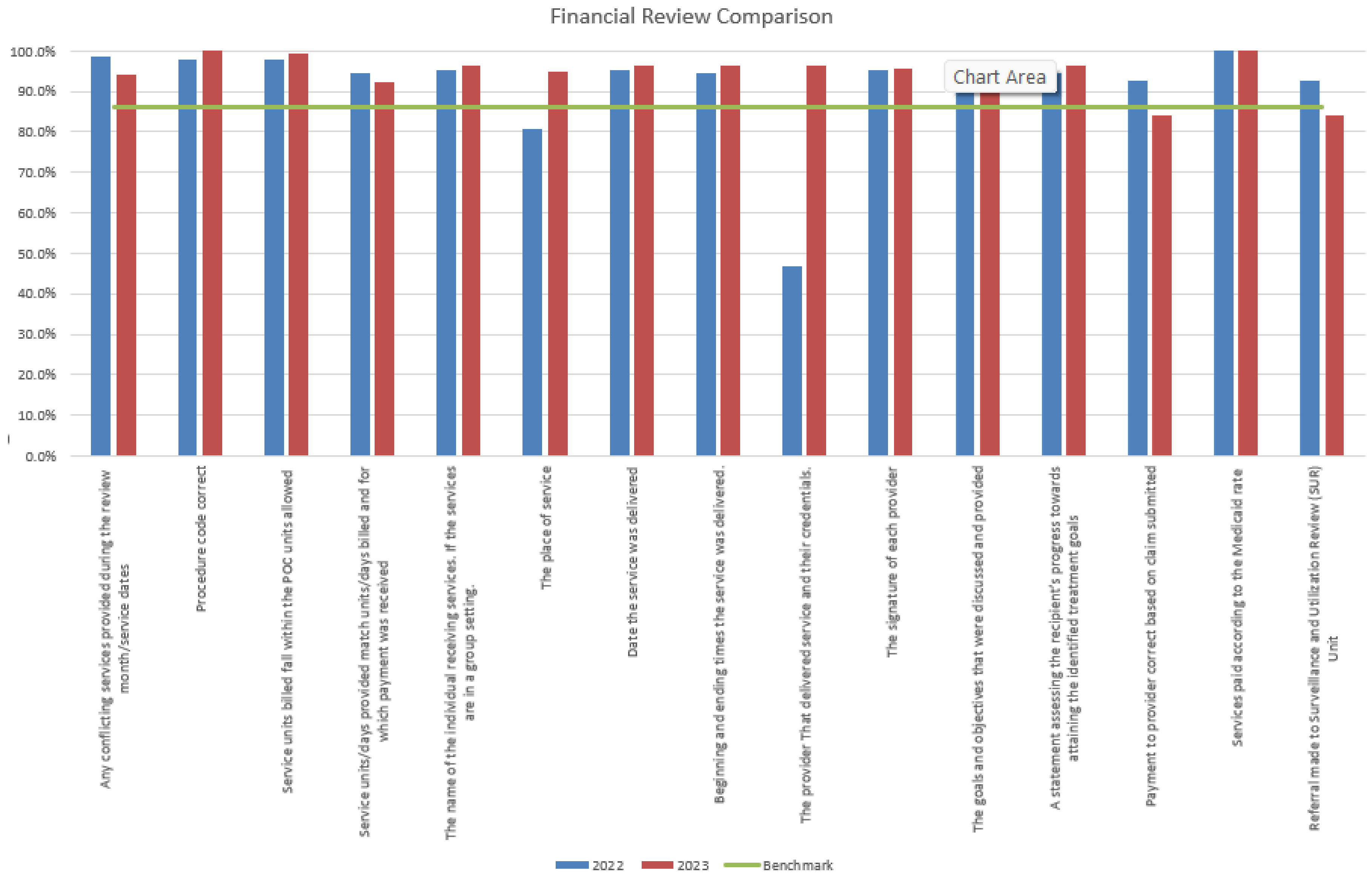
- The 1915(i) SFC policy was initially written for inclusion in DCFS' Wraparound In Nevada For Children and Families (WIN) Program, however, SFC was not included in the WIN program and became its own program. Therefore, the policy does not align with the current processes and procedures being conducted by the county and state SFC workers. Updating the policy to match the actual processes and procedures that are being conducted will assist with bringing the program into compliance.
- Policy can be updated to outline case management and service provider responsibilities. Currently it appears the service providers are documenting all required elements within their progress notes that are currently under the case management monthly monitoring duties. Case managers monthly monitoring provided during the review cycle appear to be well-check visits rather than the in-depth review of the state plan services. DHCFP QA was made aware of the detailed progress notes when the service providers submitted them during the financial reviews. It appears this element could come into compliance if the progress notes are used in place of the case management monthly notes.
- DHCFP QA has requested documentation from the case management provider(s). However, they are requesting the documentation from the service providers which results in untimely or failure to provide the required documentation to complete the review. Case management provider(s) should ensure they retain copies of all required documentation.
- Not all required documentation, such as Statement of Understanding, Acknowledgement Forms, 90-day eligibility reevaluations and 90-day POC reevaluations, were being captured by the case management providers or service providers due to a lack of understanding the policy. Clark County reported that in April 2024 their case management provider(s) implemented procedures and created new forms to ensure this documentation is being captured moving forward.
- Included in Quality Improvement (QI) meetings, discussion of the priority grid related to the state plan review elements and using the following CMS guidance:
  - Identify probable challenges to meeting compliance.
  - Develop interventions designed to improve performance.
  - Allow enough time for intervention to have an effect.

SPY 4 (2023) Financial Review Results

CLAIM	
Any conflicting services provided during the review month/service dates	94.3%
Procedure code correct	100%
Service units billed fall within the POC units allowed	99.4%
Service units/days provided match units/days billed and for which payment was received	92.4%
PROGRESS NOTES	
The name of the individual receiving services. If the services are in a group setting	96.2%
The place of service	94.9%
Date the service was delivered	96.2%
Beginning and ending times the service was delivered	96.2%
The provider that delivered service and their credentials	96.2%
The signature of each provider	95.6%
The goals and objectives that were discussed and provided	95.6%
A statement assessing the recipient's progress towards attaining the identified treatment goals	96.2%
PAYMENT	
Payment to provider correct based on claim submitted	84.2%
Services paid according to the Medicaid rate	100%
Referral made to Surveillance and Utilization Review (SUR) Unit*	15.8%
Provider eligible for payment (active) at time-of-service provision	100%

**** Denotes higher level of compliance the lower the percentage.***

SFC SPY 3 (2022) and SPY 4 (2023) Financial Review Chart Comparison



SPY 4 (2023) Financial Review Findings

Findings identify areas of deficiency discovered through the completion of the Annual Statewide SFC State Plan Review. CMS requires quality improvement projects/remediation when the threshold of compliance is below eighty-six percent (86%). For the SPY 4, 2023 review period, three (3) elements are at one hundred percent (100%) compliance:

- Procedure code correct.
- Services paid according to the Medicaid rate.
- Provider eligible for payment (active) at time-of-service provision.

In addition, there are eleven (11) elements that are above the eighty-six (86%) compliance benchmark:

- Any conflicting services provided during the review month/service dates: 94.3%
- Service units billed fall within the POC units allowed: 99.4%
- Service units/days provided match units/days billed and for which payment was received: 92.4%
- The name of the individual receiving services. If the services are in a group setting: 96.2%
- The place of service: 94.9%
- Date the service was delivered: 96.2%
- Beginning and ending times the service was delivered: 96.2%
- The provider what delivered service and their credentials: 96.2%
- The signature of each provider: 95.6%
- The goals and objectives that were discussed and provided: 95.6%
- A statement assessing the recipient's progress towards attaining the identified treatment goals: 96.2%

Quality Improvement Strategy (QIS) Project Performance

As part of the consolidated review process, DHCFP Behavioral Health (BH), DHCFP QA, DCFS operations, and the case management provider(s) gathered monthly for a Quality Improvement (QI) meeting. CMS has mandated a threshold of eighty-six percent (86%) compliance and any Performance Measure below threshold needs to be addressed. Percentages are calculated by total number provided and accurate over the total number required. (*The QIS breakdown below only covers items within DHCFP QA and DCFS operations casefile and DHCFP QA financial reviews.)*

Requirement 1: Person Centered Service Plan (PCSP aka 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.***

  SPY 4, 2023 Percentage 48.4%

  Case File Review Question 9: POC addresses assessed needs.
  In comparison to the SPY 3 review in 2022, this element shows a five percent (5%) decrease in compliance. In most cases, the deficiency was due to lack of provided documentation.

  Recommendation: During the SPY 3 review in 2022, DHCFP QA was made aware that case managers were requesting the POCs from the service providers while the financial review was underway. The case managers requested that the service providers submit the documentation directly to DHCFP QA along with the financial claims' documentation and DHCFP QA agreed to expedite the process. In the SPY 4 review of 2023, the financial review was not completed at the same time as the case file reviews and DHCFP QA relied on the case managers to provide the POCs, wherein documentation was either untimely or not provided.

- ***Sub-requirement 1-b Service plans are updated annually.***

  SPY 4, 2023 Percentage 17.3%

  Case File Review Question 4: POC updated annually or more frequently as needed.
  In comparison to the SPY 3 review in 2022, this element shows a sixteen percent (16%) decrease in compliance. In most cases, the deficiency was due to a lack of documentation and/or the inability to determine when recipients were on or off services.

  Recommendation: Case management providers should retain a copy of the POCs for all SFC recipients. State and County agencies may want to consider a system update to create an overview or summary page within their case management systems, wherein each recipient can quickly and easily be identified with current case status. In the meantime, case managers should consider adding changes to state plan eligibility status within their monthly monitoring documentation to assist with identification of recipient eligibility for annual review items. DHCFP QA will be requesting state plan eligibility timeframes, for each selected recipient, be provided with documentation to clearly define

what items are needed and what timeframes align with all annual questions.

- ***Sub-requirement 1-c Service plans document choice of services and providers.***
  SPY 4, 2023 Percentage 47.3%

  Case File Review Question 12: POC documents choice of providers/services.
  In comparison to the SPY 3 review in 2022, this element shows a six percent (6%) decrease in compliance. The deficiencies were due to lack of provided documentation.

  Recommendation: Case management providers should retain a copy of the POCs for all SFC recipients.

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.***

  SPY 4, 2023 Percentage 95.5%

  Case File Review Question 2: Meets the needs-based eligibility requirements, *Biopsychosocial Assessment (ESSII or CASII/SED) AND At Least 1 Risk Factor.*
  In comparison to the SPY 3 review in 2022, this element shows an eight percent (8%) increase in compliance. This element remains in compliance.

  Implementation: Continue to ensure all eligibility requirements are met and documented within your current checklists.

- ***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.***

  SPY 4, 2023 Percentage 1.1%

  Case File Review Question 3: Eligibility re-evaluation completed every 90 days.
  In comparison to the SPY 3 review in 2022, this element shows a one percent (1%) decrease in compliance. In most cases, the deficiency was due to a lack of documentation and/or the inability to determine when recipients were on or off services.

  Recommendation: Case management providers state their current practices are to re-evaluate eligibility annually, however, current policy requires re-evaluation more frequently and documentation was not submitted showing these were completed every ninety (90) days as dictated within policy. In addition, when questioned about recipient

eligibility timeframes, on or off state plan services, there was difficulty providing this information. State and County agencies may want to consider a system update to create an overview or summary page within their case management systems, wherein each recipient can quickly and easily be identified with current case status. In the meantime, case managers should consider adding changes to state plan eligibility status within their monthly monitoring documentation to assist with identifying recipients' eligibility for annual review items. DHCFP QA will be requesting state plan eligibility timeframes, for each selected recipient, be provided with documentation to clearly define what items are needed and what timeframes align with all annual questions. Clark County SFC case management reported that beginning April 2024, they implemented processes to complete ninety (90) day reevaluations to align with policy and bring this element into compliance.

Requirement 6: Financial Accountability

- ***Sub-requirement 6-a The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.***

  SPY 4, 2023 Percentage 100%

  Financial Review Question 16: Provider eligible for payment at time-of-service provision.
  In both the SPY 3 review in 2022 and this current SPY 4 review of 2023, this element remains at one hundred percent (100%) compliance.

  Implementation: Continue to monitor and ensure system edits around provider eligibility within MMIS are in place.

- ***Sub-requirement 6-b Number and percent of claims verified through a review of provider documentation that have been paid in accordance with the individual's service plan.***

  SPY 4, 2023 Percentage 99.4%

  Financial Review Question 8: Service units billed fall within the POC units allowed.
  In comparison to the SPY 3 review in 2022, this element shows a one percent (1.0%) increase in compliance. This element remains in compliance.

  Implementation: Continue to ensure services are provided and billed according to the POC.

Requirement 7: The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation.

- ***Sub-requirement 7-a Number and percent of 1915(i) recipients who receive information/education about how to report abuse, neglect, exploitation and other***

critical incidents.

SPY 4, 2023 Percentage 0.5%

Case File Review Question 14: Signed acknowledgement form was provided initially/annually.
In comparison to the SPY 3 review in 2022, this element shows a point five percent (0.5%) increase in compliance. The deficiency is due to a lack of understanding of policy requirement.

Recommendation: The Case management providers and service providers were not aware of policies surrounding this requirement, as such, were not collecting the acknowledgement form indicating information/education was provided about how to report abuse, neglect, exploitation and other critical incidents. Clark County created an acknowledgement form to meet this requirement and reported that beginning April 2024, case management providers have amended their practices and implemented the use of this new form to bring this element into compliance. It was later noted that this information was already being captured within the Recipient Rights that is signed at intake and administrative policy will review to see if updates are needed and to ensure all providers are reviewing and updating these with the recipient annually.

Best Practices

Best practices are methods or techniques that represent the most efficient or prudent course of action. The following practices were observed contributing to the quality of health, safety, and welfare of state plan recipients:

- Update policy to correlate with the practices and procedures of the Case Management Agencies and Providers.
- Behavioral Health is working with ADSD vendor, Therap, to be included in the replacement database that will be used to collect information regarding Serious Occurrence Reports.
- A Quality Improvement meeting was held monthly. To analyze and identify the probable cause of deficiencies and develop plans to improve performance and track improvement.

<table>
<tr><th colspan="2">CASE FILE REVIEW REQUIREMENTS</th></tr>
<tr><th colspan="2">Quality Improvement Sub Requirement, NAC, CFR, State Plan, MSM</th></tr>
<tr><th colspan="2">ELIGIBILITY</th></tr>
<tr><td>Contact made within 72 hours to schedule face-to-face</td><td>§1915(i) State Plan HCBS, Person-Centered Planning & Service Delivery, (6) Supporting the Participant in Development of Person-Centered Service Plan (effective 07/01/2021 page 18 & 03/29/2023 page 19):
Within 72 hours of notification of enrollment, the Care Coordinator contacts the participant and family to schedule a face-to face meeting.</td></tr>
<tr><td>Meets the needs-based eligibility requirements: Biopsychosocial Assessment and ECSII or CASII
AND
At Least 1 Risk Factor</td><td>Quality Improvement Sub Requirement, 2b (effective 07/01/2021 page 35 & 03/29/2023 page 36):
The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately.

CFR- § 441.720 Independent assessment, (b) (effective 01/16/2014 & 08/10/2023):
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.

§1915(i) State Plan HCBS, Evaluation/Reevaluation of Eligibility, (5) Needs-based HCBS Eligibility Criteria (effective 07/01/2021 page 9 & 03/29/2023 page 10):
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 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.

MSM Chapter 4000, Section 4003.1 A & B (1-4) (effective 10/27/2021 page 1):
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 services, have not been successful.</td></tr>
<tr><td>Eligibility reevaluation completed every 90 days completed and on basis of individual case.</td><td>Quality Improvement Sub Requirement, 2c (effective 07/01/2021 page 36 & 03/29/2023 page 37):
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, Evaluation/Reevaluation of Eligibility, (3) Process for Performing Evaluation/Reevaluation & (4) Reevaluation Schedule (effective 07/01/2021 page 8 & 03/29/2023 page 9):
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.</td></tr>
</table>

	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.
	PLAN OF CARE (POC)
POC provided (service plan/treatment plan/care plan)	**Quality Improvement Sub Requirement, (1) (effective 07/01/2021 page 29 & 03/29/2023 page 30):** Plan of Care a) address assessed needs of 1915(i) participants; b) are updated annually; and (c document choice of services and providers. **CFR- § 441.725 Person-centered service plan, (a) (03/17/2023):** 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. **§1915(i) State Plan HCBS, Person-Centered Planning & Service Delivery, (2) (effective 07/01/2021 page 15 & 03/29/2023 page 16):** 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). **MSM Chapter 4000, Section 4003.3 F(1)(b) (effective 10/27/2021 page 4):** 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). **MSM Chapter 4000, Section 4003.3 F(2)(d) (effective 10/27/2021 page 5):** The person-centered POC will include detailed service plans for applicable 191 S(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.
POC is Person Centered	**CFR § 441.725, Person-Centered Service Plan, (a) (effective 01/03/2017 & 03/11/2024):** 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, Person-Centered Service Plan (a)(4) (effective 01/03/2017 & 03/11/2024):** Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with § 435.905(b) of this chapter. **CFR § 441.725, Person-Centered Service Plan (b) (effective 01/03/2017 & 03/11/2024):** 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. **CFR § 441.725, Person-Centered Service Plan (b)(7) (effective 01/03/2017 & 03/11/2024):** Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with § 435.905(b) of this chapter. **§1915(i) State Plan HCBS, Person-Centered Planning & Service Delivery, (2) (effective 07/01/2021 page 15 & 03/29/2023 page 16):** 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). **MSM Chapter 4000, Section 4003.3 F(2)(a) (effective 10/27/2021 page 4):** 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.
Reflects strengths and preferences	**CFR-§ 441.725, Person-Centered Service Plan (b)(2) (effective 01/03/2017 & 03/11/2024):** Reflect the individual's strengths and preferences. **§1915(i) State Plan HCBS SPA, Person-Centered Planning & Service Delivery, (6) Supporting the Participant in Development of Person-Centered Service Plan (effective 07/01/2021 page 18 & 03/29/2023 page 19):** Conduct an initial assessment of strengths of the participant. **MSM Chapter 4000, Section 4003.3 F(2)(b) (effective 10/27/2021 page 4-5):** Youth and parent/guardian involvement is essential in the assessment of: strengths.
Identifies goals and desired outcomes	**CFR-§ 441.725, Person-Centered Service Plan (b)(4) (effective 01/03/2017 & 03/11/2024):** Include individually identified goals and desired outcomes. **§1915(i) State Plan HCBS SPA, Person-Centered Planning & Service Delivery, (5) Responsibility for Development of Person-Centered Service Plan (effective 07/01/2021 page 17 & 03/29/2023 page 18):** Youth and parent/guardian involvement is essential in the assessment of goals. **MSM Chapter 4000, Section 4003.3 F(2)(b) (effective 10/27/2021 page 4-5):** Youth and parent/guardian involvement is essential in the assessment of goals.
Reflects risks	**CFR-§ 441.725, Person-Centered Service Plan (b)(6) (effective 01/03/2017 & 03/11/2024):** Reflect risk factors. **§1915(i) State Plan HCBS SPA, Person-Centered Planning & Service Delivery, (5) Responsibility for Development of Person-Centered Service Plan (effective 07/01/2021 page 17 & 03/29/2023 page 18):** Youth and parent/guardian involvement is essential in the assessment of safety. **MSM Chapter 4000, Section 4003.3 F(2)(b) (effective 10/27/2021 page 4-5):** Youth and parent/guardian involvement is essential in the assessment of safety.
POC is understandable	**CFR-§ 441.725, Person-Centered Service Plan (b)(7) (effective 01/03/2017 & 03/11/2024):** Be understandable to the individual receiving services and supports. **§1915(i) State Plan HCBS SPA, Person-Centered Planning & Service Delivery, (5) Responsibility for Development of Person-Centered Service Plan (effective 07/01/2021 page 17 & 03/29/2023 page 18):** POC written in clear and understandable language. **MSM Chapter 4000, Section 4003.3 F(2)(c)(2) (effective 10/27/2021 page 5):** POC written in clear and understandable language.
Individualized back-up plan and strategies	**CFR-§ 441.725, Person-Centered Service Plan (b)(6) (effective 01/03/2017 & 03/11/2024):** Reflect individualized backup plans and strategies when needed. **NRS 424.210(3) Foster care agency which places children in specialized foster homes: Policies and procedures relating to such children; duties with respect to providers of foster care, child and biological family of child; written plan for alternative care in event of emergency:** A foster care agency which places children in a specialized foster home shall have a written plan for alternative care in the event of an emergency if the placement of the child into a specialized foster home disrupts that specialized foster home.
POC was specific/ measurable/ achievable	**§1915(i) State Plan HCBS SPA, Person-Centered Planning & Service Delivery, (5) Responsibility for Development of Person-Centered Service Plan (effective 07/01/2021 page 17 & 03/29/2023 page 18):** 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. **MSM Chapter 4000, Section 4003.3 F(2)(c)(1-3) (effective 10/27/2021 page 5):** The Care Coordinator will utilize assessments to create the person-centered POC for children and families. The plan will include needs, outcomes, and strategies that are: 1. Specific. The CFT, including the family should know exactly what must be completed or changed and why. 2. Measurable. Everyone should know when the needs have been met. Outcomes will be measurable to the extent that they are behaviorally based and written in clear and understandable language. 3. Achievable. The CFT and family should be able to meet the identified needs in a designated time period given the resources that are accessible and available to support change.
POC address assessed needs.	**Quality Improvement Sub Requirement, 1a (effective 07/01/2021 page 29 & 03/29/2023 page 30):** Service plans address assessed needs of 1915(i) participants. **CFR-§ 441.725, Person-Centered Service Plan (b)(9) (effective 01/03/2017 & 03/11/2024):** The person-centered service plan. The person-centered service plan must reflect the services and supports that are important for the individual ….as well as what is important to the individual with regard to preferences for the delivery of such services and supports. **§1915(i) State Plan HCBS SPA, Person-Centered Planning & Service Delivery, (5) Responsibility for Development of Person-Centered Service Plan (effective 07/01/2021 page 17 & 03/29/2023 page 18):** The plan will include needs. **MSM Chapter 4000, Section 4003.3 F(2)(d) (effective 10/27/2021 page 5):** The person-centered POC will include detailed service plans for applicable 1915(i) services.
POC created within 45 days of removal or the Agency's decision to provide in-home services.	**MTL # 0204 – 6162022 (effective 06/09/2022 page 12):** 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.
POC reevaluated every 90 days (thru 06/08/22) **POC reevaluated every 6 months (effective 06/09/22)**	**§1915(i) State Plan HCBS SPA, Person-Centered Planning & Service Delivery, (7) Informed Choice of Providers (effective 07/01/2021 page 19 & 03/29/2023 page 20):** 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. **MSM Chapter 4000, Section 4003.3F(1)(c) (effective 10/27/2021 page 4):** 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. **MTL # 0204 – 6162022 (effective 06/09/2022 page 1):** The frequency that a case plan must be updated was changed from every 90 days to every 6 months.
POC updated annually or more frequently as needed	**Quality Improvement Sub Requirement, 1b (effective 07/01/2021 page 30 & 03/29/2023 page 31):** Service plans are updated annually. **CFR- § 441.720, Independent assessment, (b)(7) (effective 01/03/2017 & 03/11/2024):** 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. **§1915(i) State Plan HCBS SPA, Person-Centered Planning & Service Delivery, (3) (effective 07/01/2021 page 15 & 03/29/2023 page 16):** 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. **MSM Chapter 4000, Section 4003.3 F(1)(c) (effective 10/27/2021 page 4):**

	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.
Amount/Frequency/Duration for each service.	**§1915(i) State Plan HCBS, Services, Intensive In-Home Supports and Services & Crisis Stabilization Services (effective 07/01/2020 page 22 & 24 03/29/2023 page 23):** 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. **MSM Chapter 4000, Section 4003.4 A(1) (effective 10/27/2021 page 7):** The amount, frequency and duration of this service is based on participant's assessed needs and document in the approved POC.
POC signed by CFT members, caregiver/ guardian, child/youth (if over 12 years old) and Care Coordinator.	**CFR - § 441.725 Person-Centered Service Plan (b)(9) (effective 01/03/2017 & 03/11/2024):** Commensurate with the level of need of the individual, and the scope of services and supports available under the State plan HCBS benefit, the written plan must: Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation. **§1915(i) State Plan HCBS SPA, Person-Centered Planning & Service Delivery, (7) Informed Choice of Providers (effective 07/01/2021 page 19 & 03/29/2023 page 20):** 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. **DIVISION OF CHILD AND FAMILY SERVICES/JJS 500.02 VIII(A) (effective 02/21/2022):** The CFT Facilitator shall be responsible for gaining necessary signatures on the Case Plan per Case Plan.
POC documents choice of services and providers.	**Quality Improvement Sub Requirement, 1c (effective 07/01/2021 page 30 & 03/29/2023 page 31):** Service plans document choice of services and providers. Plan of Care document choice of services and providers.
SOU signed by all participants or legal guardians.	**§1915(i) State Plan HCBS SPA, Person-Centered Planning & Service Delivery, (7) Informed Choice of Providers (effective 07/01/2021 page 19 & 03/29/2023 page 20):** 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."
Signed acknowledgement form indicating info on how to report and list of contacts for reporting critical incidences was provided initially/annually	**Quality Improvement Sub Requirement, 7 (effective 07/01/2021 page 30 & 03/29/2023 page 31):** The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation. **§1915(i) State Plan HCBS SPA, Quality Improvement Strategy, (7) Remediation Responsibilities (effective 07/01/2020 page 41 & 03/29/2023 page 43):** 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.
Monthly Monitoring: • **Strengths Identified/Updated** • **Goals/Outcomes Identified/Updated** • **Needs/Services Identified/Updated** • **Crisis Plan Reviewed** • **Mission Statement Reviewed**	**§1915(i) State Plan HCBS SPA, PERSON-CENTERED PLANNING & SERVICE DELIVERY, 6. Supporting the Participant in Development of Person-Centered Service Plan (effective 07/01/2021 page 18-19 & 03/29/2023 page 19-20):** The team, which includes the participant and his or her family and informal and formal supports will determine the family vision which will guide the planning process; identify strengths of the entire team; be notified of the needs that the team will be working on; determine outcome statements for meeting identified needs; determine the specific services and supports required in order to achieve the goals identified in the POC; create a mission statement that the team generates and commits to following; identify the responsible person(s) for each of the strategies in the POC; review and update the c7risis plan; and, meet at least every 30 days to coordinate the implementation of the POC and update the POC as necessary.

FINANCIAL REVIEW REQUIREMENTS	
	Quality Improvement Sub Requirement, NAC, CFR, State Plan, MSM
	CLAIM
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))	**MSM Chapter 4000, Section 4003.4A(2), Intensive In-Home Services (IIHS) (effective 10/27/2021)** 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 Chapter 4000, Section 4003.5A(3), Crisis Stabilization Services (CSS) (effective 10/27/2021):** Crisis Stabilization services may only be delivered in an individual, one-to-one session and are available in the child/youth's home and community.
Procedure code correct	**MSM Chapter 100, Section 105.1(F) (effective 08/28/2019):** Appropriate billings must include the current year procedure codes and ICD diagnostic codes or the HIPAA of 1996 compliant codes. Complete billing information may be obtained by contacting the Medicaid Field Representative at Medicaid's fiscal agent. Refer to Section 108 of this chapter for additional contact information. **MSM Chapter 100, Section 105.1(F) (effective 04/26/2023):** All claims submitted for payment must use the appropriate and current CPT, HCPCS, and ICD codes, and the claims must adhere to national coding standards. Additionally, the provider must comply with the Nevada Medicaid Billing Manual and Billing Guidelines. **MSM Chapter 3300 Program Integrity, Section 3303.2A(4)(a)(1)(b) (effective 05/01/2019)** Claim billed with incorrect procedure code. **MSM Chapter 3300 Program Integrity, Section 3303.4 (effective 05/01/2019):** Improper payments include but are not limited to: payments where the incorrect procedure code was billed (up-coding).
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 (additional units may be authorized)**	**MSM Chapter 4000, Section 4003.4A(1)(a)(b), Intensive In-Home Services (IIHS) (effective 10/27/2021)** a. 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. b. 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. **MSM Chapter 4000, Section 4003.5A(4), Crisis Stabilization Services (CSS) (effective 10/27/2021):** 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. **MSM Chapter 100 Medicaid Program, Section 103(B)(4) (effective 08/28/2019 & 04/26/2023)** Claims submitted are only for services rendered. **MSM Chapter 3300 Program Integrity, Section 3303.2A(4)(a)(1)(d) (effective 05/01/2019)** The number of units billed was incorrect. **MSM Chapter 3300 Program Integrity, Section 3303.4 (effective 05/01/2019):** Improper payments include but are not limited to: payments where an incorrect number of units were billed.
Service units/days provided match units/days billed and for which payment was received	**MSM Chapter 3300 Program Integrity, Section 3303.1A(2)(x)(2) (effective 05/01/2019)** False statements include submitting a bill for a service not provided. **MSM Chapter 3300 Program Integrity, Section 3303.2A(4)(a)(1)(a) (effective 05/01/2019)** No documentation or insufficient documentation provided within specified timeframes to support the service billed and paid by the DHCFP.

	MSM Chapter 3300 Program Integrity, Section 3303.2A(4)(a)(1)(d) (effective 05/01/2019): The number of units billed was incorrect.
	SERVICES
Services provided match the POC	**MSM Chapter 4000, Section 4003.3(F)(3)(a) (effective 10/27/2021):** 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. **MSM Chapter 100 Medicaid Program, Section 105.1(L) (effective 01/12/2019):** Providers are required to keep any records necessary to disclose the extent of services the provider furnishes to recipients and to provide these records, upon request, to the Medicaid agency, the Secretary of Health and Human Services (HHS), or the state Medical Fraud Control Unit (MFCU). **MSM Chapter 3300 Program Integrity, Section 3303.2B(1) (effective 05/01/2019):** 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.
Frequency of services match the POC	**CFR § 441.725, Person-Centered Service Plan (b) (effective 01/03/2017 & 03/11/2024):** Commensurate with the level of need of the individual, and the scope of services and supports available under the State plan HCBS benefit. **§1915(i) State Plan HCBS, Services, Intensive In-Home Supports and Services & Crisis Stabilization Services (effective 07/01/2020 page 22 & 24 03/29/2023 page 23):** 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. **MSM Chapter 4000, Section 4003.3(F)(3)(a) (effective 10/27/2021):** 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).
	PROGRESS NOTES MUST INCLUDE
The name of the individual receiving services. If the services are in a group setting. *(CSS can only be completed in a one-on-one)*	**MSM Chapter 4000, Section 4003.3(F)(3)(b)(1) (effective 10/27/2021):** The name of the individual receiving the service(s). If the services are in a group setting, it must be indicated.
The place of service	**MSM Chapter 4000, Section 4003.3(F)(3)(b)(2) (effective 10/27/2021):** The place of service.
Date the service was delivered	**MSM Chapter 4000, Section 4003.3(F)(3)(b)(3) (effective 10/27/2021):** The date the service was delivered.
Beginning and ending times the service was delivered	**MSM Chapter 4000, Section 4003.3(F)(3)(b)(4) (effective 10/27/2021):** The actual beginning and ending times the service was delivered.
The provider that delivered service and their credentials	**MSM Chapter 4000, Section 4003.3(F)(3)(b)(5-6) (effective 10/27/2021):** The name of the provider who delivered the service. If credentialed, the credentials of the person who delivered the Service.
The signature of each provider	**MSM Chapter 4000, Section 4003.3(F)(3)(b)(7) (effective 10/27/2021):** The signature of the provider who delivered the service.
The goals and objectives that were discussed and provided	**MSM Chapter 4000, Section 4003.3(F)(3)(b)(8) (effective 10/27/2021):** The goals and objectives that were discussed and provided during the time the services were provided.
A statement assessing the recipient's progress towards	**MSM Chapter 4000, Section 4003.3(F)(3)(b)(9) (effective 10/27/2021):** A statement assessing the recipient's progress towards attaining the identified treatment goals and objectives requested by the treatment team.

attaining the identified treatment goals	
	PAYMENT
Payment to provider correct based on claim submitted	**MSM Chapter 100 Medicaid Program, Section 105.1(F) (effective 04/27/2017):** Appropriate billings must include the current year procedure codes and ICD diagnostic codes or the HIPAA of 1996 compliant codes. Complete billing information may be obtained by contacting the Medicaid Field Representative at Medicaid's fiscal agent. Refer to Section 108 of this chapter for additional contact information. **MSM Chapter 100 Medicaid Program, Section 105.1(F) (effective 04/26/2023):** All claims submitted for payment must use the appropriate and current CPT, HCPCS, and ICD codes, and the claims must adhere to national coding standards. Additionally, the provider must comply with the Nevada Medicaid Billing Manual and Billing Guidelines. **MSM Chapter 3300 Program Integrity, Section 3303.2A(4)(1)(a)(2)(d) (effective 05/01/2019):** The incorrect rate was used to pay the claim. **MSM Chapter 3300 Program Integrity, Section 3302.4 (effective 05/01/2019):** Improper payments include but are not limited to: payments that cannot be substantiated by appropriate or sufficient medical or service record documentation.
Services paid according to the Medicaid rate	**MSM Chapter 100 Medicaid Program, Section 105.1(F) (effective 08/28/2019):** Appropriate billings must include the current year procedure codes and ICD diagnostic codes or the HIPAA of 1996 compliant codes. Complete billing information may be obtained by contacting the Medicaid Field Representative at Medicaid's fiscal agent. Refer to Section 108 of this chapter for additional contact information. **MSM Chapter 100 Medicaid Program, Section 105.1(F) (effective 08/28/2019):** All claims submitted for payment must use the appropriate and current CPT, HCPCS, and ICD codes, and the claims must adhere to national coding standards. Additionally, the provider must comply with the Nevada Medicaid Billing Manual and Billing Guidelines. **MSM Chapter 3300 Program Integrity, Section 3302.4 (effective 05/01/2019):** An improper payment is any payment that is payment over Medicaid allowable amounts. **MSM Chapter 3300 Program Integrity, Section 3303.2B(4) (effective 05/01/2019):** Improper payments include but are not limited to: Payments where the incorrect procedure code was billed (up-coding); payments over Medicaid allowable amounts.
Overpayment to provider	**MSM Chapter 3300 Program Integrity, Section 3302.4 (effective 05/01/2019):** An improper payment is any payment that is billed to or paid by the DHCFP that is not in accordance with: The Medicaid or Nevada Check Up policy governing the service provided; fiscal agent billing manuals; contractual requirements; standard record keeping requirements of the provider discipline; and federal law or state statutes. An improper payment can be an overpayment or an underpayment. Improper payments.
Referral made to Surveillance and Utilization Review (SUR) Unit	**§1915(i) State Plan HCBS SPA, Quality Improvement Strategy, (6) (effective 07/01/2020 & 03/29/2023):** 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. **MSM Chapter 100 Medicaid Program, Section 106.5(C) (effective 08/28/2019 & 04/26/2023):** The DHCFP may initiate a corrective action plan against a provider as the result of an investigation, audit and/or review. Investigations, audits or reviews may be conducted by one or more of the following (not all inclusive): c. Nevada Medicaid Surveillance Utilization and Review (SUR) staff. **MSM Chapter 3300 Program Integrity, Section 3302.4 (05/01/2019):** An improper payment is any payment that is billed to or paid by the DHCFP that is not in accordance with: The Medicaid or Nevada Check Up policy governing the service provided; fiscal agent billing manuals; contractual requirements; standard record keeping requirements of the provider discipline; and federal law or state statutes. An improper payment can be an overpayment or an underpayment. Improper payments include but are not limited to: improper payments discovered during federal PERM reviews or Financial and Policy Compliance Audits; payments for ineligible recipients; payments for ineligible, non-covered or unauthorized services; duplicate payments; payments for services that were not provided or received; payments for unbundled services when an all-inclusive bundled code should have been billed; payments not in accordance with applicable pricing or rates; data entry errors resulting in incorrect payments; payments

	where the incorrect procedure code was billed (up-coding); payments over Medicaid allowable amounts; payments for non-medically necessary services; payments where an incorrect number of units were billed; submittal of claims for unauthorized visits; and payments that cannot be substantiated by appropriate or sufficient medical or service record documentation. Improper payments can also be classified as fraud and/or abuse.
Provider eligible for payment (active) at time-of-service provision	**MSM Chapter 4000, Section 4003.3(B) (effective 10/27/2021):** 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 Chapter 100 Medicaid Program, Section 102 (effective 08/28/2019):** All individuals/entities providing services to Medicaid recipients under the FFS or Medicaid Managed Care program must be enrolled as a Medicaid provider in order to receive payment for services rendered. **MSM Chapter 100 Medicaid Program, Section 102(2) (effective 04/26/2023):** All individuals/entities who provide services to Nevada Medicaid recipients under the FFS and/or Medicaid Managed Care Organization (MCO) program shall be enrolled as a Nevada Medicaid provider in order to receive payment for services rendered.

Acronyms & Definitions 1915(i) SFC & 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 state plan 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.

PCSP- (PERSON-CENTERED SERVICE PLAN) aka
POC- (PLAN OF CARE)
A written document identifying the recipient's health and welfare needs, along with goals and interventions to meet the identified needs. It specifies the level of assistance, type, amount, scope, duration, and frequency for all services, as well as other ongoing community support services that may meet the assessed needs of the recipient, regardless of the funding source.

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.

SHA- (SOCIAL HEALTH 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)
SOU- (STATEMENT OF UNDERSTANDING)
A form given to all applicants describing the services offered under the state plan during the intake process. The assigned Service Coordinator informs the applicant of their choice between state plan services and 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 state pan 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.