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
Nevada Health Authority | Nevada Medicaid
Quality, Access and Availability Unit
August 2025
Review Year: State Plan Year (SPY) 5

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ANNUAL STATEWIDE 1915(i) HCBS STATE PLAN SFC FINAL REPORT

State Plan Year 5 (2024)

Background/Introduction

The State Plan (SP) 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 SP 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(b): "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 must be implemented unless the state provides acceptable justification clarifying why system improvement is unnecessary.

Quality Improvement Strategy

CMS evaluates the state's oversight and monitoring systems according to outcome-based evidence in the form of Quality Improvement Strategy (QIS). A well-crafted QIS indicates whether the state meets the federal requirements for the approved SP benefit. The QIS form the basis of the evidence provided to CMS.

The state's QIS are assessed by CMS and must address all of the following requirements:

1. Incorporate a continuous quality improvement process that includes monitoring, remediation, and quality improvement, including recognizing and reporting critical incidents, as defined in §441.302(a)(6)(i)(A), except that the references to section 1915(c) of the Act are instead references to section 1915(i) of the Act.

2. Be evidence-based, and include outcome measures for program performance, quality of care, and individual experience as determined by the Secretary.

3. Provide evidence of the establishment of sufficient infrastructure to implement the program effectively.

4. Measure individual outcomes associated with the receipt of HCBS, related to the implementation of goals included in the individual service plan.

5. Implementation of the Home and Community-Based Services Quality Measure Set in accordance with § 441.312, except that the references to section 1915(c) of the Act are instead references to section 1915(i) of the Act.

Aims & Objectives

The annual review monitoring activities provides the foundation for quality improvement by generating information regarding compliance, potential problems, and corrective action activities. The results can be aggregated and analyzed to measure the overall system performance in meeting the program 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 Nevada Medicaid (DNM) 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 SP allowing a ten percent (10%) sample size. The sample size is used to determine the required number of recipient cases that DNM 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 DNM QA and DCFS, however, due to changes within the Operating Agency, all reviews for this plan year were conducted solely by DNM QA. The ten percent (10%) sample size is also used to determine the required number of financial reviews DNM QA will need to complete for each state plan year. Financial reviews were conducted during the months of May and June 2025, covering one (1) random month's sample of claims within the one (1) year program look-back.

The annual review period for the HCBS SFC State Plan Year (SPY) five (5) covered July 1, 2024 through June 30, 2025. The ten percent (10%) review requirement determined a sample size of sixty-nine (69) reviews. Out of the sixty-nine (69) required financial recipient reviews, DNM QA reviewed sixty-six (66) recipients, as three (3) recipients had no billed claims, resulting in one hundred seventy-one (171) claims reviewed.

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

Case File Review:

1. State Plan Eligibility
2. State Plan Service Received
3. Person Centered Service Plan (PCSP)
4. Monthly Monitoring
5. Annual Forms

Financial Review:

1. Claim
2. Progress Notes
3. Payment

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

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

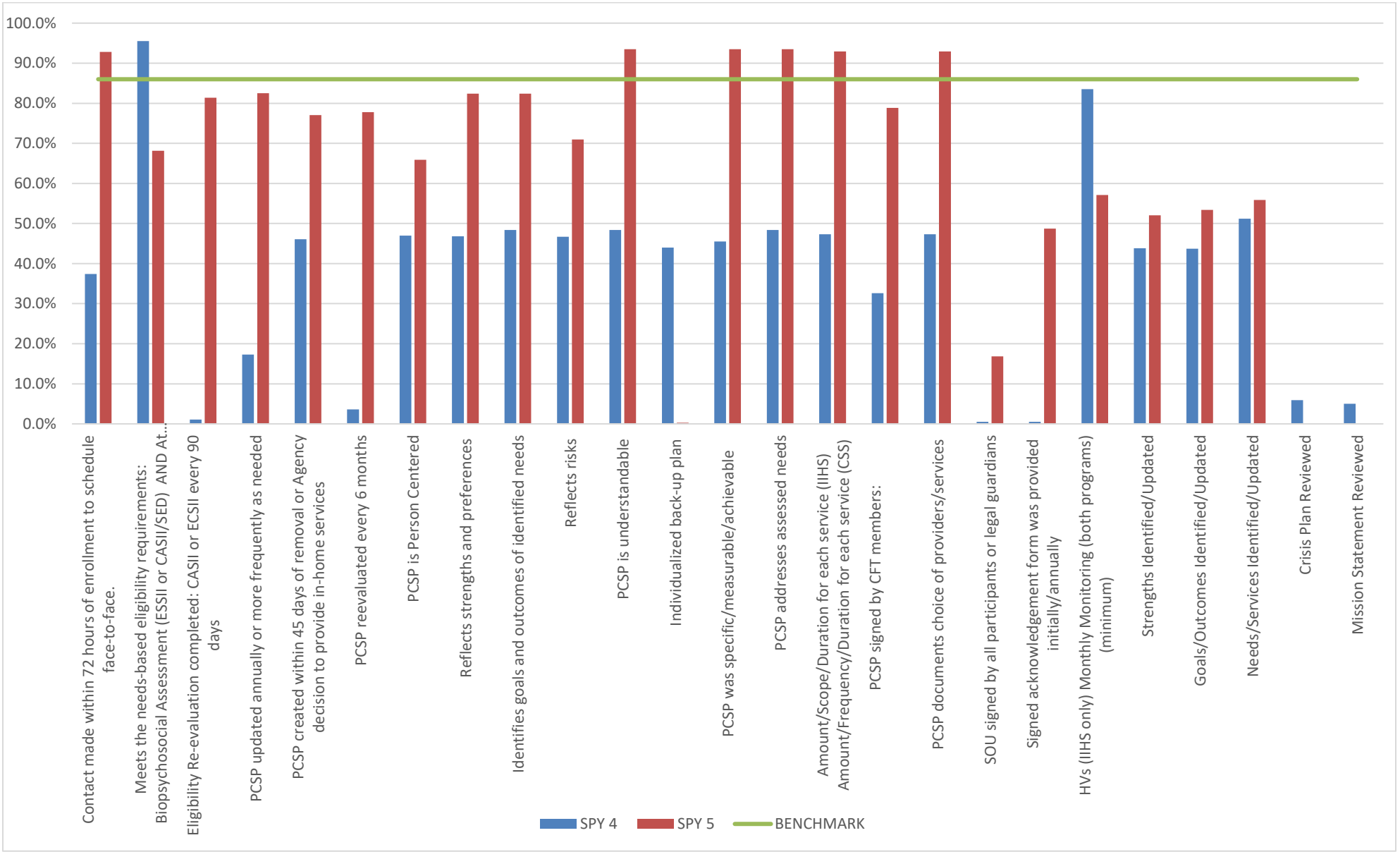
- MSM Chapter 4000 HCBS State Plan Option Intensive In-Home Services (IIHS) and Crisis Stabilization (CS) (Effective 10/27/2021)
- MSM Chapter 3300 Program Integrity (Effective 05/01/2019)
- State Plan: 1915(i) HCBS State Plan Services (Amendment effective 03/29/2023)
- Social Security Act: 1915(i) (1)(a) through (j)
- 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 measures and requirements outlined above.

SPY 5 (2024) Case File Review Results

ELIGIBLITY	
Contact made within 72 hours of enrollment to schedule face-to-face. (Per SP Initially)	92.8%
Meets the needs-based eligibility requirements Biopsychosocial Assessment (ESSII or CASII/SED) AND at Least 1 Risk Factor	68.2%
Eligibility Re-evaluation completed: CASII or ECSII every 90 days	81.4%
SFC PERSON CENTERED SERVICE PLAN (PCSP)	
PCSP updated annually or more frequently as needed	82.5%
PCSP created within 45 days of removal or Agency decision to provide in-home services	77.0%
PCSP re-evaluated every 6 months	77.8%
PCSP is Person Centered	65.9%
a. Reflects strength and preferences	82.4%
b. Identifies goals and outcomes of identified needs	82.4%
c. Reflects risks	71.0%
d. PCSP is understandable	93.5%
e. Reflect individualized back-up plan	0.3%
PCSP was specific/measurable/achievable	93.5%
PCSP addresses assessed needs	93.5%
Amount/Scope/Duration for each service (IIHS) Amount/Frequency/Duration for each service (CSS)	92.9%
PCSP signed by CFT members: Caregiver, Support Persons, Child/youth (as applicable), Care Coordinator and Service Provider	78.9%
PCSP documents choice of providers/services	92.9%
FORMS	
SOU signed by all participants or legal guardians was provided initially	16.9%
Signed acknowledgement form was provided initially/annually	48.7%
MONTHLY MONITORING	
Home visits (IIHS only), Monthly Monitoring (both IIHS and CS)	57.1%
Strengths identified/updated	52.0%
Goals/Outcomes identified/updated	53.4%
Needs/Services identified/updated	55.9%
Crisis Plan reviewed	0.0%
Mission Statement reviewed	0.0%

SFC SPY 4 (2023) and SPY 5 (2024) Case File Review Chart Comparison



SPY 5 (2024) 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 compliance is below eighty-six percent (86%). For the SPY 5, 2024 review period, six (6) elements have been identified as being in compliance:

- Contact made within 72 hours enrollment to schedule face-to-face: 92.8%
- PCSP is understandable: 93.5%
- PCSP was specific/measurable/achievable: 93.5%
- PCSP addresses assessed needs: 93.5%
- Amount/Scope (IIHS)/Duration/Frequency (CSS) for each service: 92.9%
- PCSP documents choice of providers/services: 92.9%

All other areas were under compliance, however, only reportable areas are detailed within the Quality Improvement Strategy (QIS) Project Performance on page 11.

Observations and Recommendations:

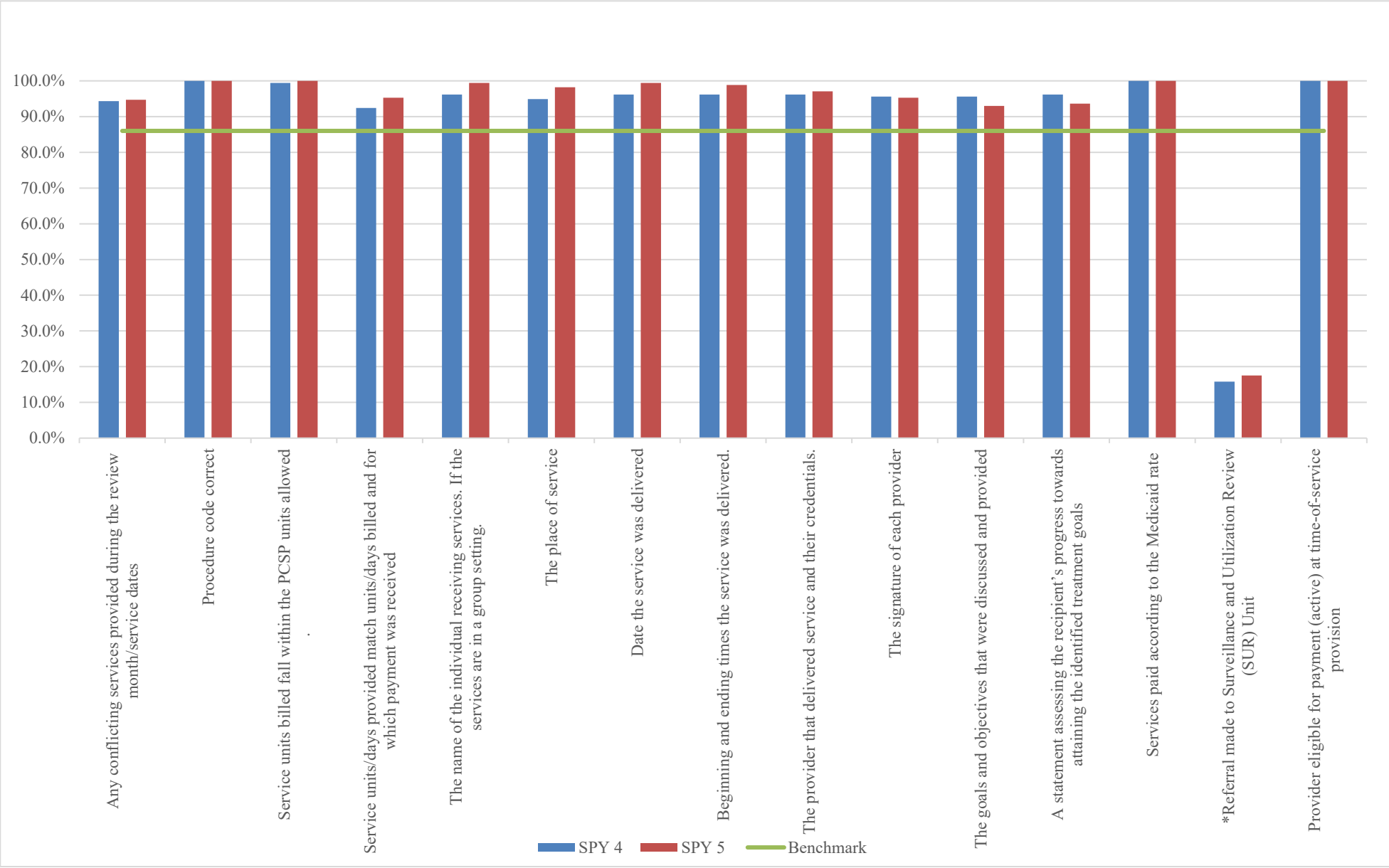
- DNM Behavioral Health (BH) Benefits Coverage Unit has been updating policy to better align with current practices.
- Currently service providers are documenting all MSM elements of monitoring within their progress notes. However, MSM requires the case managers to conduct the monthly monitoring. Review of the case managers' documentation appears to indicate that well-check visits are occurring rather than the in-depth review of the state plan services. DNM QA recommends review and possible update of policy regarding who should complete the monitoring.
- DNM QA requests documentation from the case management provider(s), however, they are requesting documentation from the service providers. This results in untimely or missing documentation to complete the review. Case management providers will begin to retain copies of all required documentation to ensure timeliness of submission to complete the annual review.
- Not all required documentation, such as Statement of Understanding, Acknowledgement Forms, 90-day eligibility reevaluations and six-month PCSP reevaluations, were being captured by case management providers or service providers due to a lack of understanding of the policy. During monthly Quality Improvement (QI) meetings with case management providers, clarification was provided on how field workers are capturing the required information. QA relayed expectations and requirements around case file reviews in QI meetings. QA also held discussions and reviewed a priority grid related to elements under tolerance and using the following CMS guidance:
    - Identify probable barriers to meet compliance.
    - Develop interventions designed to improve performance.
    - Allow enough time for intervention to have an effect.

SPY 5 (2024) Financial Review Results

CLAIM	
Any conflicting services provided during the review month/service dates	94.7%
Procedure code correct	100%
Service units billed fall within the PCSP units allowed	100%
Service units/days provided match units/days billed and for which payment was received	95.3%
PROGRESS NOTES	
The name of the individual receiving services. If the services are in a group setting	99.4%
The place of service	98.2%
Date the service was delivered	99.4%
Beginning and ending times the service was delivered	98.8%
The provider that delivered service and their credentials	97.1%
The signature of each provider	95.3%
The goals and objectives that were discussed and provided	93.0%
A statement assessing the recipient's progress towards attaining the identified treatment goals	93.6%
PAYMENT	
Services paid according to the Medicaid rate	100%
Referral made to Surveillance and Utilization Review (SUR) Unit*	17.5%
Provider eligible for payment (active) at time-of-service provision	100%

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

SFC SPY 4 (2023) and SPY 5 (2024) Financial Review Chart Comparison



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

SPY 5 (2024) 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 compliance is below eighty-six percent (86%). For the SPY 5, 2024 review period, there were no areas out of compliance, with four (4) elements at one hundred percent (100%):

- Procedure code correct.
- Service units billed fall within the PCSP units allowed.
- Services paid according to the Medicaid rate.
- Provider eligible for payment (active) at time-of-service provision.

All remaining elements, ten (10) in total, are at or above ninety-three percent (93%).

Quality Improvement Strategy (QIS) Project Performance

As part of the consolidated review process, DNM BH, DNM QA, DCFS operations, and the case management provider(s) gathered monthly for QI meetings. CMS has mandated a threshold of eighty-six percent (86%) compliance and any measure below threshold needs to be addressed. Percentages are calculated by the total number provided and accurate over the total number required. (*The QIS breakdown below only covers items within DNM QA casefile and financial reviews, remaining QIS elements are tracked/reported by DNM BH.)*

Requirement 1: Person Centered Service Plan (PCSP or 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 5, 2024 Percentage 93.5%

  Case File Review Question 9: PCSP addresses assessed needs.
  In comparison to the SPY 4 review in 2023, this element shows a forty-five point one percent (45.1%) increase in compliance. This element has come into compliance.

  Implementation: Case management providers ensure the assessed needs are listed on the PCSP(s). DNM QA has been receiving documentation and has worked with case management and services providers to clarify the specific requirements for each recipient case file review. This clarification has resulted in better communication and correct documentation being provided to DNM QA.

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

  SPY 5, 2024 Percentage 82.5%

  Case File Review Question 4: PCSP updated annually or more frequently as needed.
  In comparison to the SPY 4 review in 2023, this element shows a sixty-five point two

percent (65.2%) increase in compliance. This element is close to coming into compliance, with a 3.5% increase needed. In most cases, the deficiency was due to a lack of documentation.

Recommendation: Case management providers will retain a copy of the PCSPs for all recipients. DNM QA and DNM BH partnered with the case management and service providers to clarify review requirements and time frames for the reviews. DNM QA will be requesting case management providers to complete and submit a QA Checklist for each selected recipient with the documentation submission packet. The QA Checklist itemizes the documentation required and provides a way to double check that all documentation was included in the packet.

- ***Sub-requirement 1-c Service plans document choice of services and providers.***

  SPY 5, 2024 Percentage 92.9%

  Case File Review Question 12: PCSP documents choice of providers/services.
  In comparison to the SPY 4 review in 2023, this element shows a forty-five point six percent (45.6%) increase in compliance. This element has come into compliance.

  Implementation: Case management providers retain a copy of the PCSPs for all recipients and ensure the PCSP documents the choice of services and providers. Service providers have updated their PCSP template to include a section where the choice of services and providers is addressed.

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 5, 2024 Percentage 68.2%

  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 4 review in 2023, this element shows a twenty-seven point three (27.3%) decrease in compliance. This element has fallen out of 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: With better policy guidance and collaboration between DNM BH,

DNM QA, and case management providers it was found that the risk factor was missing from the biopsychosocial assessment and/or the checklists were not provided. Case management providers will retain a copy of the eligibility checklists and/or the biopsychosocial assessment with a risk factor in the recipient's file. It is also recommended that each case management provider completes and submits a QA Checklist to ensure no documents are missing and that eligibility timeframes are noted.

- ***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 5, 2024 Percentage 81.4%

  Case File Review Question 3: Eligibility re-evaluation completed every 90 days.
  In comparison to the SPY 4 review in 2023, this element shows an eighty point three percent (80.3%) increase in compliance. This element is close to coming into 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 every ninety (90) days. Documentation was not submitted showing these were completed as dictated within policy. In addition, when questioned about recipient eligibility timeframes, on or off state plan services, there was difficulty providing this information. DNM QA will be requesting case management providers to complete and submit a QA Checklist for each selected recipient with the documentation submission packet. The QA Checklist itemizes the documentation required and eligibility timeframes. 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. Through QI meetings and collaboration with case management and service providers, it was identified that field staff were uncertain about the documentation required to meet this requirement. DNM QA and DNM BH jointly worked to define the necessary documentation.

Requirement 6: Financial Accountability

The State Medicaid Agency (SMA) maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.

- ***Sub-requirement 6-a Number and percent of claims paid to 1915(i) service providers who are qualified to furnish 1915(i) services to 1915(i) recipients.***

  SPY 5, 2024 Percentage 100%

  Financial Review Question 16: Provider eligible for payment at time-of-service

provision.
In both the SPY 4 review in 2023 and this current SPY 5 review of 2024, 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 5, 2024 Percentage 100%

  Financial Review Question 3: Service units billed fall within the PCSP units allowed.
  In comparison to the SPY 4 review in 2023, this element shows a zero point six (0.6%) increase in compliance. This element remains in compliance.

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

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 5, 2024 Percentage 48.7%

  Case File Review Question 14: Signed acknowledgement form was provided initially/annually.
  In comparison to the SPY 4 review in 2023, this element shows a forty-eight point two percent (48.2%) increase in compliance. This element remains out of compliance. In most cases, the deficiency is due to a lack of understanding of policy requirements and a lack of documentation being submitted.

  Recommendation: 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. It was noted that this information was already being captured within the Recipient Rights that is signed at intake. Case management and service providers collaborated to ensure this documentation is captured and is submitted timely, and as such, DNM QA believes this element will come into compliance within the next review period.

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 and service providers.

- DNM QA developed a QA Checklist for case management providers to assist in collecting all required documentation and eligibility timeframes. This checklist itemizes the documentation needed to complete a case file review for each recipient.

- DNM BH and DNM QA collaborated to ensure when policy updates are required the appropriate changes are made to continue promoting the health, safety, outcomes, and welfare of recipients. Through this collaboration a better understanding of the policy was able to be curated and communicated with partners.

- DNM BH is working with ADSD vendor, Therap, to be included in the replacement database that will be used to collect information regarding Critical Incidents/Serious Occurrence Reports (SOR), also known as a General Event Report (GER) within this new system.

- A QI meeting is held monthly to analyze and identify the probable cause of deficiencies and develop plans to improve performance. DNM BH also holds state-wide service and case management provider meetings to better communicate policy changes and updates.

Conclusion

The review of monitoring activities serves as a foundation for ongoing quality improvement efforts. The DNMBH, DCFS, case management providers, and QA teams focused on identifying key areas for improvement by evaluating current policy requirements and updating them to reflect current practices. According to CMS guidelines, quality improvement initiatives are required when compliance falls below 86%. During the annual review, it was found that essential documentation—such as the Statement of Understanding, Acknowledgment Forms, 90-day eligibility re-evaluations, and six-month PCSP re-evaluations—were not consistently submitted due to a lack of understanding around policy requirements.

Through collaborative clarification between BH, QA, DCFS, and case management providers, and by aligning policies with current practices, six elements were found to be in compliance—an improvement from the previous year (SPY 4), where only one element met compliance.

Monthly Quality Improvement (QI) meetings have been instrumental in identifying barriers and developing strategies to enhance program performance. One key issue addressed was the delay in documentation caused by case management providers relying on service providers for required documentation. Moving forward, case management providers will retain all necessary documentation to ensure timely annual reviews. QA also addressed gaps in documentation due to policy misunderstandings wherein our case management providers created and implemented processes to address this which have significantly improved compliance and should be in compliance within the next state plan review period. Notably, all financial submissions reviewed during this period met or exceeded the 86% compliance threshold required by CMS.

Case File Review Requirements	
Quality Improvement Sub Requirement, NAC, CFR, State Plan, MSM	
ELIGIBILITY	
Contact made within 72 hours to schedule face-to-face	**§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.
Meets the needs-based eligibility requirements: **Biopsychosocial Assessment and ECSII or CASII** **AND** **At Least 1 Risk Factor**	**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, (c) (effective 01/16/2014 & 08/10/2023):** The person-centered service plan must be reviewed, and revised upon reassessment of functional need as required in § 441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual. **§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) for youth ages 0-5 or the Child and Adolescent Service Intensity Instrument (CASII) for youth ages 6-18. The Wraparound Facilitator and CFT will review clinical indicators of impaired functioning: Prior psychological assessment records, prior placement history, and prior treatment history. Youth must demonstrate significant levels of behavioral health needs as evidenced by a minimum CASII or ECSII level of 1. AND 2. Other Community Alternatives: The accessibility and/or intensity of currently available community supports and services are inadequate to meet these needs due to the severity of the impairment without the provision of one or more of the services contained in the HCBS Benefit, as determined by the DCFS or its designee, as evidenced by at least one of the following risk factors: • At risk of higher level of care placement due to recent placement disruption within the past six months; • Current placement in emergency shelter or congregate care due to behavioral and mental health needs; • In need of transition to community-based living arrangement with intensive behavioral supports when returning or stepping down from residential treatment center or other higher level of care placement; and/or • At risk of higher level of care placement because prior traditional family foster care and/or less restrictive community treatment services have not been successful. **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.
Eligibility reevaluation completed every 90 days completed and on basis of	**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.

individual case.	**§1915(i) State Plan HCBS, Evaluation/Reevaluation of Eligibility, (3) Process for Performing Evaluation/Reevaluation (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. 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.
	PERSON CENTERED SERVICE PLAN (PCSP)
PCSP provided (service plan/treatment plan/care plan)	**Quality Improvement Sub Requirement, (1) (effective 07/01/2021 page 29 & 03/29/2023 page 30-32):** Person centered service plan 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 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 person centered service plan 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 PCSP 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.
PCSP 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 PCSP 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.
PCSP 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):** PCSP written in clear and understandable language. **MSM Chapter 4000, Section 4003.3 F(2)(c)(2) (effective 10/27/2021 page 5):** PCSP 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.
PCSP 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 PCSP 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 PCSP 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.
PCSP 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 PCSP will include detailed service plans for applicable 1915(i) services.
PCSP 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.
PCSP reevaluated every 90 days (thru 06/08/22) **PCSP 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 PCSP 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 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. **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.
PCSP 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 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.
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.
PCSP 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.
PCSP 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. Person centered service plan 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**	**§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 crisis plan; and, meet at least

Identified/Updated **• Crisis Plan Reviewed** **• Mission Statement Reviewed**	every 30 days to coordinate the implementation of the PCSP and update the PCSP 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))	**§1915(i) State Plan (HCBS), Administration and Operation (8) Non-duplication of services (effective 07/01/2020):** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973. **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. **MSM Chapter 3300 Program Integrity, Section 3303.2A(4)(a)(2)(a) (effective 05/01/2019)** Duplicate claims billed for same service, same recipient and same date of service.
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 3302.4 (effective 05/01/2019):** Improper payments include but are not limited to: payments where the incorrect procedure code was billed (up-coding). **MSM Chapter 3300 Program Integrity, Section 3303.2A(4)(a)(1)(b) (effective 05/01/2019)** Claim billed with incorrect procedure code.
Service units billed fall within the PCSP 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. **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).
Service units/days provided match units/days billed and for which payment was received	**MSM Chapter 100 Medicaid Program, Section 103(B)(4) (effective 04/26/2023):** Claims submitted are only for services rendered. **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. **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.
	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 attaining the identified treatment goals	**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.
	PAYMENT
Services paid according to the Medicaid rate	**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):** Improper payments include but are not limited to: Payments over Medicaid allowable amounts. **MSM Chapter 3300 Program Integrity, Section 3302.6 (effective 05/01/2019):** 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 Chapter 3300 Program Integrity, Section 3303.2A(2)(d) (effective 05/01/2019):** Incorrect rate was used to pay the claim.
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 102A(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

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 INTESITY 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 SERVICES)
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.

DNM- (DIVISION OF NEVADA MEDICAID - FORMERLY 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-TR- (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 DNM 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 population 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 Nevada Health Authority (NVHA).

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.

NVHA- (NEVADA HEALTH AUTHORITY)
The Nevada Health Authority brings together the strengths of several key agencies under one roof to better serve Nevadans—leveraging our buying power, streamlining services, and driving innovation while staying true to our state's values of fiscal discipline and decisive leadership.

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 DNM 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-TR, 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 – (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.