ANNUAL STATEWIDE 1915(i) HOME & COMMUNITY BASED SERVICES (HCBS) STATE PLAN ADULT DAY HEALTH CARE (ADHC) & HOME BASE HABILITATION SERVICES (HBHS) REVIEW FINAL REPORT 2023

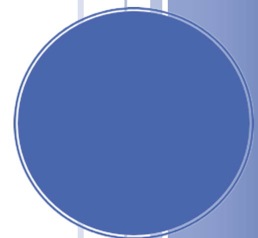
HCBS Serving Individuals enrolled in ADHC and HBHS Quality Assurance (QA) review to ensure the service continues to meet essential federal statutory assurances and effectively meet the recipient's needs.

State of Nevada

Division of Health Care Financing and Policy
Quality, Access and Availability Unit

May 2024

State Plan Year 4



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Background/Introduction

The State Plan Amendment (SPA) renewal of the Adult Day Health Care (ADHC) and Home Base Habilitation Services (HBHS) are 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 Home Based Habilitation Services (HCBS) meets federal and state guidelines for quality assurance. In addition, under 42 Code of Federal Regulation (CFR) §441.745: "States must develop and implement an HCBS quality improvement strategy that includes a continuous improvement process and measures of program performance and experience of care. The strategy must be proportionate to the scope of services in the state plan HCBS benefit and the number of individuals to be served." CMS must assess each state plan HCBS benefit to determine that the state requirements are met. The assessment also serves to inform CMS in its review of the state's request for renewal of these services.

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

A **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 not necessary.

Performance Measures

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

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

1. The performance measure is stated as a metric (e.g., number or percent), and specifies a numerator and denominator (e.g., is the performance measure measurable?).
2. The performance measure has face validity (e.g., Does the performance measure truly measure the requirement?).
3. The performance measure data is based on the correct unit of analysis (e.g., participants, providers, claims, etc.). The unit of analysis should be linked to the requirement measured.
4. The performance measure data is based on a representative sample of the population. The performance measure data should have at least a ninety-five percent (95%) confidence level with a +/- ten percent (10%) margin of error. If the state chooses to stratify a sample to allow for a representative sample of subgroups, the state must "re-weight" the data in order to make estimates for the population as a whole.
5. The performance measure must provide data specific to the state plan benefit undergoing evaluation.
6. The performance measure data demonstrates the degree of compliance for each period of data collection.
7. The performance measure determines the health of the system, (e.g., does the performance measure evaluate the anticipated outcome of the requirement as opposed to measuring a beginning step in the process?).

Aims & Objectives

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

Methodology

CMS quality requirements are founded on an evidence-based approach. CMS requests evidence from the state that it meets the assurances and applies a continuous quality improvement approach to the assurances. The Division of Health Care Financing and Policy (DHCFP) Quality Assurance (QA) Unit implemented a monthly process to allow the state to achieve higher administrative efficiency, a natural process of current and continuous quality improvement, and prevent duplication. The DHCFP QA unit uses a representative sample. Effective October 24, 2022, CMS approved an amendment to the State Plan Administration (SPA) allowing a ten percent (10%) sample size of all recipients active/inactive during the review period. The sample size is used to determine the required number of recipient cases that DHCFP QA and LTSS unit staff will evaluate throughout the review year. The total number is distributed evenly over the year. All recipients' cases selected will be evaluated using the twelve (12) months immediately preceding the month the review is conducted. The ten percent (10%) sample is also used to determine the required number of financials DHCFP QA will review. The financial review is completed at the end of the State Plan year and once all the recipients have been selected.

The annual review for the HCBS state plans ADHC & HBHS for the State of Nevada was conducted from March 1, 2023, through February 29, 2024. The ten percent (10%) sample size of one hundred twenty-three (123) reviews required. Sixty-one (61) reviews were assigned to the DHCFP QA unit, and the remaining sixty-two (62) reviews were completed by the DHCFP LTSS 1915i team. The DHCFP QA unit reviewed one hundred twenty-three (123) recipient's financial claims, wherein six (6) had no billed claims in the month selected from January 1, 2023, through November 30, 2023.

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

Case File Review:

1. State Plan Eligibility
2. State Plan Service Received
3. Service Plan (SP)
4. Prior Authorization (PA)
5. DHCFP Plan of Care (POC)
6. Statement of Choice (SOC)
7. Acknowledgement Form

Financial Review:

1. Recipient Eligibility
2. PA
3. Claim
4. Daily Record
5. Payment
6. Provider

At the beginning of the plan year, both the case file and financial review forms were updated to ensure all review elements were supported in policy, having removed any obsoleted questions no longer supported with policies within the one year look back.

Listed below are the specific 1915(i) ADHC and HBHS, Medicaid Services Manual (MSM), State Plan, CFRs, Final Rule CMS, Nevada Administrative Code and Policy and Procedure used in the implementation of this annual review:

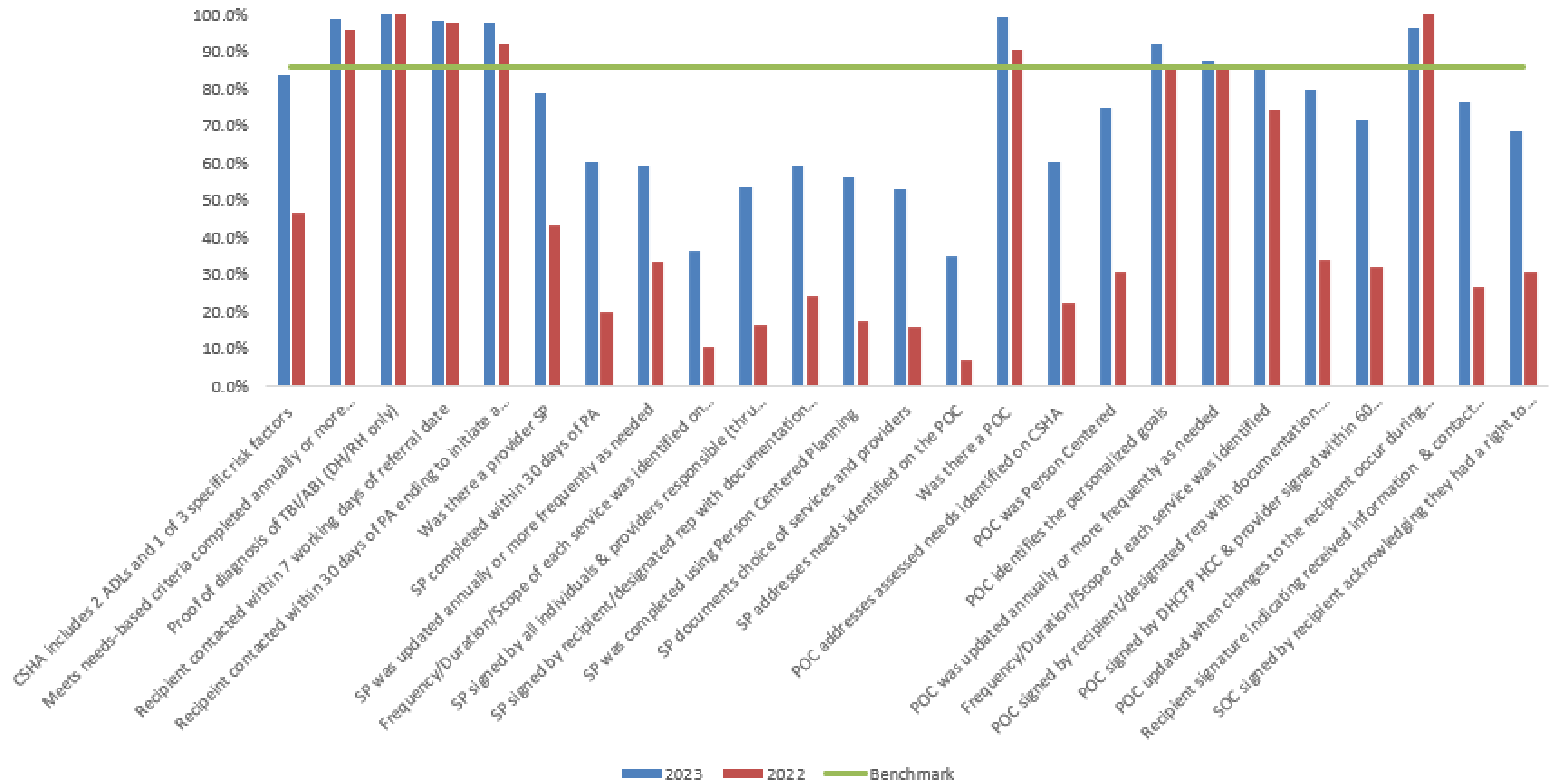
- MSM Chapter 100 Medicaid Program (Effective 08/28/2019, Amended 04/26/2023)
- MSM Chapter 1800 HCBS State Plan Option Adult Day Healthcare and Habilitation (Effective 03/01/2020, Amended 02/01/2023 and Amended 01/01/2024)
- MSM Chapter 3300 Program Integrity (Effective 05/01/2019)
- State Plan: 1915(i) HCBS State Plan Services (Effective 03/01/2020, Amended 07/01/2020 and Amended 01/01/2024)
- CFR- 441-540/CFR- 441.720/CFR-441.725
- Final Rule CMS 2249-F & CMS 2296-F
- Nevada Administrative Code (NAC) 449.4087/NAC 449.4088
- Policy and Procedure (P&P) Adult Day Health Care and Habilitation Policy and Procedure Memo 2024-1

The following results identify the areas and percentages of compliance with Quality Improvement Strategy (QIS) and requirements outlined in the above policies.

2023 Statewide Case File Review Results

ADHC/DHRH

Eligibility	
SHA includes 2 ADLs & 1 of 3 specific risk factors	83.6%
SHA completed annually or more frequently as needed	98.6%
Proof of diagnosis of TBI/ABI (DH/RH only)	100.0%
Recipient contacted within 7 working days of referral date	98.4%
Recipient contacted within 30 days of PA ending to initiate a face-to-face re-evaluation	97.6%
Provider Service Plan (SP)	
Was there a provider SP	78.9%
SP completed within 30 days of PA	60.2%
SP was updated annually or more frequently as needed	59.5%
Frequency/Duration/Scope of each service was identified on the SP	36.2%
SP signed by all individuals & providers responsible	53.6%
SP signed by recipient/designated rep with documentation	59.4%
SP was completed using Person Centered Planning	56.2%
SP documents choice of services and providers	53.1%
SP addresses needs identified on the POC	34.9%
DHCFP Plan of Care (POC)	
Was there a POC	99.2%
POC addresses assessed needs identified on SHA	60.1%
POC is person centered	75.0%
a. Residence chosen by recipient	37.5%
b. Opportunities to access community/employment	31.3%
c. Reflects strengths and preferences	36.7%
d. POC identifies the personalized goals	91.9%
e. Reflect risk factors	77.5%
f. POC is understandable	97.3%
g. Recipient's back up plan/strategies	29.2%
POC was updated annually or more frequently as needed	87.6%
Frequency/Duration/Scope/Amount of each service was identified	85.0%
POC signed by recipient/designated rep with documentation (New referrals only, within 60 days of SOU)	79.6%
POC signed by DHCFP HCC & provider signed within 60 days of POC date	71.2%
POC updated when changes to the recipient occur during authorization period	96.4%
Recipient signature indicating received information & contact list for reporting critical incidences at initial and annual assessments	76.4%
SOC signed by recipient acknowledging they had the right to choose the services and providers at initial assessment	68.6%


ADHC Chart Comparison
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
CSHA includes 2 ADLs and 1 of 3 specific risk factors
Meets needs-based criteria completed annually or more...
Proof of diagnosis of TBI/ABI (DH/RH only)
Recipient contacted within 7 working days of referral date
Recipeint contacted within 30 days of PA ending to initiate a...
Was there a provider SP
SP completed within 30 days of PA
SP was updated annually or more frequently as needed
Frequency/Duration/Scope of each service was identified on...
SP signed by all individuals & providers responsible (thru...
SP signed by recipient/designated rep with documentation...
SP was completed using Person Centered Planning
SP documents choice of services and providers
SP addresses needs identified on the POC
Was there a POC
POC addresses assessed needs identified on CSHA
POC was Person Centered
POC identifies the personalized goals
POC was updated annually or more frequently as needed
Frequency/Duration/Scope of each service was identified
POC signed by recipient/designated rep with documentation...
POC signed by DHCFP HCC & provider signed within 60...
POC updated when changes to the recipient occur during...
Recipient signature indicating received information & contact...
SOC signed by recipient acknowledging they had a right to...
2023
2022
Benchmark

2023 Case File Reviews

The annual combined review shows one (1) measure is at 100% compliance:

- Proof of diagnosis of TBI/ABI

In addition, there are seven (7) areas that are above the 86% compliance benchmark:

- Meets needs-based criteria completed annually or more frequently as needed – 98.6%
- Recipient contacted within 7 working days of referral date – 98.4%
- Recipient contacted within 30 days of PA ending to initiate a face-to-face re-evaluation – 97.6%
- POC identified the personalized goals – 91.9%
- POC is understandable – 97.3%
- POC was updated annually or more frequently as needed – 87.6%
- POC updated when changes to the recipient occur during authorization period – 96.4%

Quality Improvement Strategy

(Percentages calculated by dividing the number correctly provided by the total number of answers.)

* QIS noted below are elements reviewed and reported to by DHCFP QA. All other elements not addressed below are reported directly from DHCFP LTSS 1915(i) team.

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

Sub-requirement 1-a Service plans address assessed needs of 1915(i) participants.

ADHC & HBHS Combined **47.5%**
Questions 14 and 16

- **Question 14: Service Plan (SP) addresses needs identified on the POC** (34.9%): In comparison to the 2022 plan year, this question shows a twenty-eight percent (28.0%) increase in compliance. These deficiencies were due to either the provider SP not being uploaded into OnBase, or the provider SP did not address all needs reported on the plan of care.

  Implementation: MSM was amended on January 1, 2024, and no longer requires the provider SP to be reviewed for the addressed needs of the recipient. The policy was amended to ensure providers follow the DHCFP person centered plan of care (POC). The POC is developed with the recipient to identify the individual's needs, risks and goals to meet or mitigate the identified needs and risks.

- **Question 16: POC addresses assessed needs identified on Social Health Assessment (SHA)** (60.1%): In comparison to the 2022 plan year, this question shows a thirty-eight percent (38%) increase in compliance. In most cases, the deficiency was due to the POC missing needed services identified on the SHA.

  Implementation: DHCFP LTSS 1915(i) team implemented a desk manual for HCCs to use to complete their assessments. The desk manual has been updated throughout the year as well as one-on-one and group meetings and trainings with the HCCs. DHCFP LTSS completed reviews of completed case files to ensure best practices are being followed. On Apil 16th, 2024, DHCFP QA held a meeting with HCCs addressing changes in QA's review. QA has aligned the review to reflect all the implemented changes in policy and will only conduct a "deep dive review" of the current POC. DHCFP QA will review allowing for a percentage-based calculation of assessed needs noted on the SHA to the assessed needs documented on the POC.

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

ADHC & HBHS Combined 73.5%
Questions 8 and 18

- **Question 8: SP was updated annually or more frequently as needed** (59.5%): In comparison to the 2022 plan year, this question shows a twenty-six percent (26.0%) increase in compliance. In most cases, the deficiency was due to the provider SP not being uploaded into OnBase.

  Implementation: MSM was amended on January 1, 2024, and no longer requires the provider SP to be reviewed. Moving forward, the providers will provide services for needs that are identified on the DHCFP POC.

- **Question 18: POC was updated annually or more frequently as needed** (87.6%): In comparison to the 2022 plan year, this question shows a one percent (1.0%) increase in compliance. This element remains in compliance.

  Implementation: DHCFP LTSS 1915(i) team implemented a desk manual for the HCCs to use. The desk manual has been updated throughout the year and quarterly meetings have been held with HCCs to ensure best practices are being followed. The manual reinforces timeframes are being adhered to as well as the POCs being uploaded to SAMs or OnBase once signed.

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

ADHC & HBHS Combined 53.1%
Question 13

- **Question 13: SP documents choice of services and providers** (53.1%): In comparison to the 2022 plan year, this question shows a thirty-seven percent (37.0%) increase in compliance. In most cases, the deficiency was due to the provider SP not being uploaded into OnBase.

  Implementation: MSM was amended on January 1, 2024, and no longer requires the provider SP to be reviewed. The DHCFP LTSS 1915(i) POC has already been amended to include the verbiage to ensure choice is addressed with the recipient.

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-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.

ADHC & HBHS Combined 100%

- This element is reviewed and tracked at one hundred percent (100%) by DHCFP LTSS 1915(i) team.

Sub-requirement 2-b The process and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately.

ADHC & HBHS Combined 83.6%
Questions 1

- **Question 1: SHA includes 2 ADLs and 1 of 3 specific risk factors** (83.6%): In comparison to the 2022 plan year, this question shows a thirty-seven percent (37%) increase in compliance. In most cases, the deficiency was due to the SHA not clearly documenting the specific risk factor used for approval.

  Implementation: DHCFP LTSS 1915(i) team implemented a desk manual for HCCs to use to complete the SHA. The desk manual has been updated throughout the year as well as one-on-one and group meetings and trainings with the HCCs. This question is under compliance as QA reviewed SHAs created prior to implementation of the desk manual and lacked correct documentation of a risk factor. With the implementation of the desk manual, meetings and trainings this assurance is expected to come into compliance in the next state plan year.

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.

ADHC & HBHS Combined **98.6%**
Questions 2

- **Question 2: SHA completed annually or more frequently as needed** (98.6%): In comparison to the 2022 plan year, this question shows a three percent (3%) increase in compliance. This element remains in compliance.

  Implementation: DHCFP LTSS 1915(i) team implemented a desk manual for HCCs to use to complete the SHA which reinforces timeframes are being adhered to. The desk manual has been updated throughout the year as well as one-on-one and group meetings and trainings with the HCCs. DHCFP LTSS completed reviews of completed case files to ensure best practices are being followed.

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.

ADHC & HBHS Combined **100%**
Questions 16

- **Question 16: Provider eligible for payment at time-of-service provision** (100%): In comparison to the 2022 plan year, this question remains in compliance.

  Implementation: Ensure providers are qualified to provide services.

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.

ADHC & HBHS Combined **75%**
Questions 8

- **Question 8: Service units/days provided match units/days billed and for which payment was received** (75%): In comparison to the 2022 plan year, this question remained the same. In most cases, the provider did not provide the attendance logs or did not ensure the recipient signed the attendance log to verify services/days matched units/days billed for which payment was received. In other cases, the provider billed under the incorrect service type when the recipient was between day and residential habilitation programs.

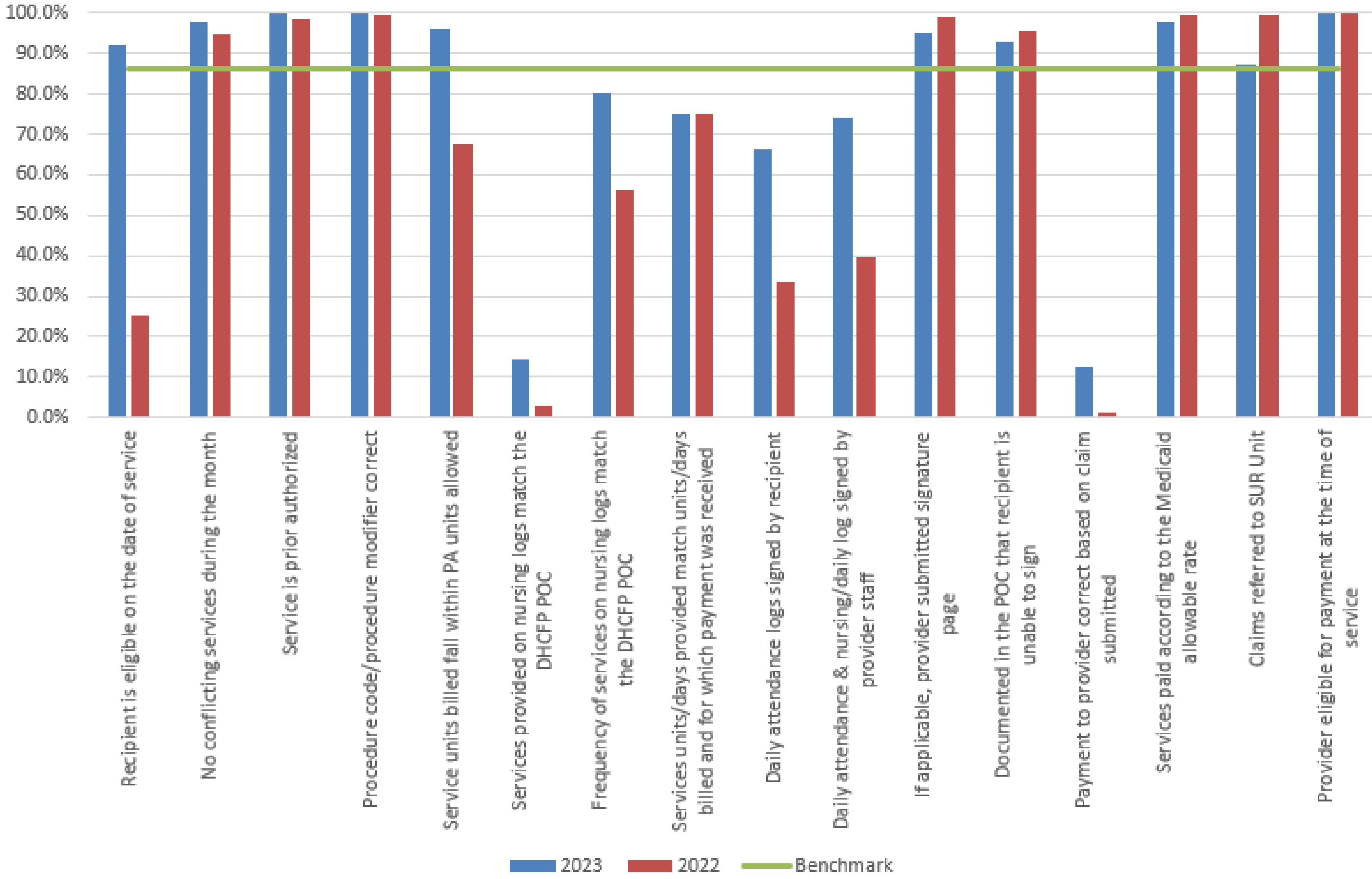
  Recommendation: Providers ensure they are submitting all attendance logs as well as confirm the recipient is signing the logs in order to validate services/days matched

units/days billed for which payment was received. Providers need to ensure proper coding in order to validate the correct service provided to a recipient receiving both day and residential habilitation programs.

2023 Statewide Financial Review Results Combined for ADHC & HBHS

State Plan Eligibility	
Recipient is eligible on the date of service	92.2%
No conflicting services during the month	97.7%
Service Authorization	
Service is prior authorized	100%
Claim	
Procedure code correct	100%
Service units billed fall within the PA units allowed	96.1%
Daily Record	
Services provided on nursing logs match the DHCFP POC	14.1%
Frequency of services match the DHCFP POC	80.5%
Service units/days provided match units/days billed and for which payment was received	75.0%
Daily attendance logs signed by recipient	66.4%
Daily attendance & nursing/daily log signed by provider staff	74.2%
If applicable, documented recipient is unable to sign due to cognitive &/or physical limitations	95.3%
If applicable, provider submitted signature page	93.0%
Payment	
Payment to provider is correct based on claim submitted	12.5%
Services paid according to the Medicaid allowable rate	97.6%
Referral made to Surveillance and Utilization Review (SUR) Unit	87.5%*
Provider	
Provider eligible for payment at time of service	100%

**Denotes measures for which a higher percentage rate suggests lower compliance.*



Financial Review Comparison
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Recipient is eligible on the date of service
No conflicting services during the month
Service is prior authorized
Procedure code/procedure modifier correct
Service units billed fall within PA units allowed
Services provided on nursing logs match the DHCFP POC
Frequency of services on nursing logs match the DHCFP POC
Services units/days provided match units/days billed and for which payment was received
Daily attendance logs signed by recipient
Daily attendance & nursing/daily log signed by provider staff
If applicable, provider submitted signature page
Documented in the POC that recipient is unable to sign
Payment to provider correct based on claim submitted
Services paid according to the Medicaid allowable rate
Claims referred to SUR Unit
Provider eligible for payment at the time of service
2023
2022
Benchmark

2023 Financial Review

The annual combined financial review three (3) measures are at 100% compliance:

- Provider eligible for payment at time of service
- Service is prior authorized
- Procedure code

In addition, there are six (6) additional measures that are above the 86% compliance benchmark:

- Enrollee eligible on the date of service – 92.2%
- No conflicting services during the month – 97.7%
- Service units billed fall within the POC units allowed – 96.1%
- Documented that recipient is unable to sign – 95.7%
- Provider submitted signature page – 99.1%
- Services paid according to the Medicaid allowable rate – 97.6%

DHCFP LTSS 1915(i) team continues to conduct Provider Reviews going forward and entering information into ALiS (Online Provider Review System) database to be tracked and flagged for deficiencies. Depending on the deficiencies, DHCFP LTSS 1915(i) team will send referrals to the appropriate state agency for review and create a corrective action plan, if necessary.

Additional Recommendations

- Ensure SHAs clearly call out the Risk Factor and are completed annually or as needed.
- Ensure all needed documents are signed and uploaded into OnBase.
- Use a calendar alert system, if possible, for time sensitive documents. This will allow the HCCs to recognize which items need action on any given date.
- Ensure the needs/requested services documented in the SHA are identified in the POC.
- Ensure only appropriate services for the selected provider are documented on the POC.
- Continue to have quarterly meetings with providers to ensure understanding and importance of adherence to new policies and procedures.

Observations

- DHCFP QA holds a monthly QI meeting (DHCFP LTSS 1915(i) team and DHCFP QA unit) to go over the results for the case files reviews that were conducted.
- In an effort to eliminate duplication of efforts by HCCs and providers the removal of requirements to review the provider service plan was proposed and amended. DHCFP LTSS 1915(i) team held a public workshop on October 11, 2023, and a public hearing on December 26, 2023, wherein the updating of MSM 1800 was amended effective January 1, 2024.
- DHCFP LTSS 1915(i) ensured all referrals and reassessments were completed correctly.
- DHCFP LTSS 1915(i) team held in-service trainings on the needs-based criteria, specific risk factors, POCs, frequency/duration/scope, and signatures.
- DHCFP LTSS 1915(i) team held monthly meetings and trainings with all HCCs to focus on issues identified in the DHCFP QA priority grid.
- DHCFP LTSS 1915(i) team held individual meetings and trainings with all HCCs on recently completed new referrals, ongoing cases, discussed deficiencies and made remediation plans when necessary.

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 and welfare of state plan recipients:

- Monthly Quality improvement meetings were held with DHCFP QA and DHCFP LTSS 1915(i) team.
- Quarterly priority grid meetings were held to discuss remediation for measures under compliance.
- DHCFP LTSS 1915(i) team and HCCs met monthly or one-on-one to communicate issues to bring up compliance.
- On 04/03/2023, DHCFP QA provided DHCFP LTSS 1915(i) team had a consistency meeting to discuss the case file review form.
- On 12/05/2023, DHCFP QA and DHCFP LTSS 1915(i) team had a meeting with providers to discuss the upcoming financial reviews and explain what is needed for review.
- On 03/26/2024, DHCFP QA and DHCFP LTSS 1915(i) team had a meeting with providers to discuss the outcome of the financial reviews.

1915(i) ADHC CASE FILE REVIEW REQUIREMENTS

<table>
<tr><th colspan="2">Quality Improvement Sub Requirement, NAC, CFR, State Plan, MSM</th></tr>
<tr><th></th><th>ELIGIBILITY</th></tr>
<tr><td>1) SHA includes 2 ADLs and 1 of 3 specific risk factors.</td><td>Quality Improvement Sub Requirement 2b (effective 07/01/2020):
The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately.

CFR § 441.720, Independent assessment (a) (effective 01/03/2017 & 03/11/2024):
Requirements. For each individual determined to be eligible for the State plan HCBS benefit, the State must provide for an independent assessment of needs, which may include the results of a standardized functional needs assessment, in order to establish a service plan.

CFR § 441.720, Independent assessment (a)(7) (effective 01/03/2017 & 03/11/2024):
Include in the assessment, for individuals receiving habilitation services, documentation that no Medicaid services are provided which would otherwise be available to the individual, specifically including but not limited to services available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973, or the Individuals with Disabilities Education Improvement Act of 2004.

§1915(i) State Plan HCBS, Evaluation/Reevaluation of Eligibility, (5) HCBS Eligibility Criteria (effective 03/01/2020):
A recipient must need assistance or prompting in at least two Activities of Daily Living (bathing,
dressing, grooming, toileting, transfer, mobility, eating) and must also have one of the following risk factors:
At risk of social isolation due to lack of family or social supports.
At risk of a chronic medical condition being exacerbated if not supervised by a registered nurse;
or
A history of aggressive behavior if not supervised or if medication is not administered by a
registered nurse.

MSM Chapter 1800, Section 1803.1 (effective 03/01/2020 & 02/01/2023):
The DHCFP 1915(i) Home and Community-Based Services (HCBS) State Plan Option utilizes a needs-based criteria to evaluate and reevaluate whether an individual is eligible for services. The criteria considers the individual’s support needs and risk factors.

In order to be eligible, a recipient must need assistance or prompting in at least two Activities of Daily Living (ADL) which includes bathing, dressing, grooming, toileting, transfer, mobility, eating and must also have one of the following risk factors:
1. At risk of social isolation due to lack of family or social supports;
2. At risk of a chronic medical condition being exacerbated if not supervised by a registered nurse (RN); or
3. A history of aggressive behavior if not supervised or if medication is not administered by an RN.

The DHCFP Health Care Coordinator (HCC) conducts the needs-based eligibility determinations.
2. Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility is applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.

MSM Chapter 1800, Section 1803.1A(2)(b) (effective 03/01/2020):
Day habilitation-targeted to individuals with Traumatic Brian Injury (TBI) or Acquired Brain Injury (ABI).

MSM Chapter 1800, Section 1803.1A(2)(b) (effective 02/01/2023):
Day Habilitation-targeted to individuals with Traumatic Brian Injury (TBI) or Acquired Brain Injury (ABI) as diagnosed by a physician.

MSM Chapter 1800, Section 1803.1A(2)(c) (effective 03/01/2020):
Residential Habilitation-targeted to individuals with TBI or ABI.

MSM Chapter 1800, Section 1803.1A(2)(c) (effective 02/01/2023)</td></tr>
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	Residential Habilitation-targeted to individuals with TBI or ABI as diagnosed by a physician.
2) SHA completed annually or more frequently as needed.	**Quality Improvement Sub Requirement 2c (effective 07/01/2020):** 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. **CFR § 441.720, Independent assessment (b) (effective 01/03/2017 & 03/11/2024):** 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, (4) Reevaluation Schedule (effective 03/01/2020):** Needs-based eligibility reevaluations are conducted at least every twelve months. **MSM Chapter 1800, Section 1803.6C(1)(a) (effective 03/01/2020):** Prior to the 12-month authorization period ending, the Health Care Coordinator will contact the recipient within 30 days to initiate a re-evaluation. The re-evaluation includes a face-to-face assessment to determine whether the recipient continues to meet needs-based criteria. The POC will be updated during the re-evaluation assessment and the recipient/designated representative will receive a copy of the POC which must be signed. **MSM Chapter 1800, Section 1803.6A(2)(a) & (b) (effective 02/01/2023):** Once a recipient is authorized for 1915(i) services, that authorization period is for 12-months from the date of authorization. a. Prior to the 12-month authorization period ending, the HCC will contact the recipient within 30 days to initiate a re-evaluation. The re-evaluation includes a face-to-face assessment or via telehealth under certain circumstances, to determine whether the recipient meets the needs-based criteria. b. If a recipient has a change in condition during the authorization period, the HCC will contact the recipient/designated representative to discuss the changes and update the POC, as applicable.
3) Proof of diagnosis of TBI/ABI.	**Quality Improvement Sub Requirement 2c (effective 07/01/2020):** 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 **NAC 449.4087, Written assessments of clients (1)(2)(3)(4) (Added to NAC by Bd. of Health, (effective 06/23/1986):** Upon admission, an initial written assessment must be made of any person admitted to the facility. Within 30 days after admission, another written assessment must be completed which must include: An evaluation of the client's physical and mental health; A history of the client's social development; A list of formal and informal systems for emotional support which are available to the client; An evaluation of the tasks required for daily living that can be performed by the client; A list of programs for financial assistance which are available to the client and the plan for care of the client. **§1915(i) State Plan HCBS, Evaluation/Reevaluation of Eligibility (7) Target Group (effective 03/01/2020):** Recipients 18 years and over. For Day and Residential Habilitation Services, individuals must have a Traumatic Brain Injury (TBI) or an Acquired Brain Injury (ABI). **MSM Chapter 1800, Section 1803.1A(2)(b) & (c) (effective 03/01/2020):** b. Day habilitation-targeted to individuals with Traumatic Brian Injury (TBI) or Acquired Brain Injury (ABI). c. Residential Habilitation-targeted to individuals with TBI or ABI. **MSM Chapter 1800, Section 1803.1A(2)(b) & (c) (effective 02/01/2023):** b. Day Habilitation-targeted to individuals with Traumatic Brian Injury (TBI) or Acquired Brain Injury (ABI) as diagnosed by a physician. c. Residential Habilitation-targeted to individuals with TBI or ABI as diagnosed by a physician.
4) Recipient contacted within 7 working days of referral date.	**MSM Chapter 1800, Section 1803.6A(2) (effective 03/01/2020):** If an applicant appears to meet program criteria, a face-to-face visit will be scheduled to assess needs-based eligibility using the Comprehensive Social Health Assessment (SHA) tool. The DHCFP Health Care Coordinator will contact the applicant/representative within seven working days of the referral date to schedule a time to conduct an assessment. **MSM Chapter 1800, Section 1803.6A(1)(d) (effective 02/01/2023):** If an applicant appears to meet program criteria, a face-to-face assessment or via telehealth under certain circumstances, will be scheduled to determine needs-based eligibility using the Comprehensive Social Health Assessment (SHA) tool. The DHCFP HCC will contact the applicant/representative within seven (7) working days of the referral date to schedule a time to conduct an assessment.
5) Recipient	

contacted within 30 days of PA ending to initiate a face-to-face re-evaluation.	
	PROVIDER SERVICE PLAN (SP)
6) Was there a provider SP.	**CFR § 441.725, Person-centered service plan (a) (effective 01/03/2017 & 03/11/2024):** a. Person-centered planning process. Based on the independent assessment required in § 441.720, the State must develop (or approve, if the plan is developed by others) a written service plan jointly with the individual (including, for purposes of this paragraph, the individual and the individual's authorized representative if applicable). The person-centered planning process is driven by the individual. **§1915(i) State Plan HCBS, Person-Centered Planning & Service Delivery (2) (effective 03/01/2020):** 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. **MSM Chapter 1800, Section 1803.1B(7) (effective 03/01/2020):** The service plan is developed by the provider using the 1915(i) HCBS Plan of Care (POC) and includes the identified needs from the POC. The service plan must include the description of services and amount of time (hourly, daily, weekly). **MSM Chapter 1800, Section 1803.1B(7) (effective 02/01/2023):** The Service Plan (SP) is developed by the provider using the 1915(i) HCBS Plan of Care (POC). At the minimum, a provider's SP must include: the description of services, duration and amount of time (hourly, daily, weekly). The provider must also ensure the recipient, or the recipient's designated representative, is fully involved in the person-centered planning process which is documented on the SP.
7) SP completed within 30 days of PA.	**MSM Chapter 1800, Section 1803.1B(7) (effective 03/01/2020):** A service plan must be completed within 30 days of the recipient beginning services. **MSM Chapter 1800, Section 1803.1B(7)(a) (effective 02/01/2023):** The completed, signed, and dated SP must be sent to 1915i@dhcfp.nv.gov within 60 calendar days of the recipient beginning or continuing services.
8) SP was updated annually or more frequently as needed.	**Quality Improvement Sub Requirement 1-b (effective 07/01/2020):** Service plans are updated annually. **CFR § 441.720, Independent assessment (b) (effective 01/03/2017 & 03/11/2024):** 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, Person-Centered Planning & Service Delivery (3) (effective 03/01/2020):** 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 1800, Section 1803.1B(7)(a) (effective 02/01/2023):** The completed, signed, and dated SP must be sent to 1915i@dhcfp.nv.gov within 60 calendar days of the recipient beginning or continuing services.
9) Frequency/ Duration/Scope of each service was identified on the SP.	**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. **§1915(i) State Plan HCBS, Services, Adult Day Healthcare, Day Habilitation and Residential Habilitation (effective 03/01/2020 & 01/01/2024)** Specify limits (if any) on the amount, duration, or scope of this service. **MSM Chapter 1800, Section 1803.1B(7) (effective 03/01/2020):** The service plan is developed by the provider using the 1915(i) HCBS Plan of Care (POC) and includes the identified needs from the POC. The service plan must include the description of services and amount of time (hourly, daily, weekly).

	MSM Chapter 1800, Section 1803.1B(7) (effective 02/01/2023): The Service Plan (SP) is developed by the provider using the 1915(i) HCBS Plan of Care (POC). At the minimum, a provider's SP must include: the description of services, duration and amount of time (hourly, daily, weekly). The provider must also ensure the recipient, or the recipient's designated representative, is fully involved in the person-centered planning process which is documented on the SP.
10) SP signed by all individuals & providers responsible. (effective 03/01/2020) **SP must be signed by appropriate staff. (effective 02/01/2023)**	**CFR § 441.725, Person-centered service plan, (b)(9) (effective 01/03/2017 & 03/11/2024):** 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, Evaluation/Reevaluation (2) Qualifications of Individuals Performing Evaluation/Reevaluation. (effective 03/01/2020):** The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. **MSM Chapter 1800, Section 1803.1B(7) (effective 03/01/2020):** The provider may create a signature page which can encompass a recipient signature for the Service Plan and any other signature requirements. If the provider uses a signature page, it must be included in the recipient file. **MSM Chapter 1800, Section 1803.1B(7)(b)(1) (effective 02/01/2023):** The SP must be signed by the appropriate staff as referenced in 1803.3B(3)(c)(1), 1803.4B(2)(c)(1), 1803.5B(2)(c)(1), as applicable. ADHC 1803.3B (3)(c)(1) The appropriate staff member includes, but not limited to: the RN, the LPN under the direct supervision of the RN, or the Program Director. Day Hab 1803.4B (2)(c)(1) The recipient and the appropriate staff member must sign or initial each record. The appropriate staff member would include, but not limited to: Director of the facility or designated acting Director. Res Hab 1803.5B(2)(c)(1) I THINK THIS IS WRONG, SHOULD BE 1803.5B(2)(b)(1) The recipient and the appropriate staff member must sign or initial each record. The appropriate staff member would include, but not limited to: Administrator or the employee designated to be in charge of the facility when the administrator is absent.
11) SP signed by recipient/designated rep with documentation. (effective 03/01/2020) **SP signed by recipient/designated rep within 60 calendar days of the recipient beginning or continuing services. (effective 02/01/2023)**	**Quality Improvement Sub requirement 2-b (effective 07/01/2020):** The processes and instruments described in the approved state plan for determining 1915(i) eligibilities are applied appropriately. **CFR § 441.720, Independent assessment, (b)(9) (effective 01/03/2017 & 03/11/2024):** 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. **MSM Chapter 1800, Section 1803.1B(7) (effective 03/01/2020):** The recipient must provide a signature on the Service Plan. If the recipient is unable to provide a signature due to cognitive and/or physical limitation, this must be clearly documented in the recipient file. A designated representative may sign for the recipient. **MSM Chapter 1800, Section 1803.1B(7)(a) (effective 02/01/2023):** The recipient must also provide a signature on the SP. If the recipient is unable to provide a signature due to cognitive and/or physical limitation, this must be clearly documented in the recipient's file. A designated representative may sign for the recipient as referenced in 1803.6C(7)(c). The provider may create a signature page which a designated representative should sign on behalf of the recipient for the SP and any other signature requirements. If the provider uses a signature page, it must be included in the recipient file. a. Timeframes-The completed, signed, and dated SP must be sent to 1915i@dhcfp.nv.gov within 60 calendar days of the recipient beginning or continuing services.
12) SP was completed using Person Centered Planning.	**Quality Improvement Sub requirement 2-b (effective 07/01/2020):** The processes and instruments described in the approved state plan for determining 1915(i) eligibilities are applied appropriately. **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)(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 03/01/2020):** 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 1800, Section 1803.1B(7) (effective 03/01/2020 & 02/01/2023):** The Service Plan (SP) is developed by the provider using the 1915(i) HCBS Plan of Care (POC). At the minimum, a provider's SP must include: the description of services, duration, and amount of time (hourly, daily, weekly). The provider must also ensure the recipient, or the recipient's designated representative, is fully involved in the person-centered planning process which is documented on the SP.
13) SP documents choice of services and providers.	**Quality Improvement Sub requirement 1-c (effective 07/01/2020):** Plan of Care document choice of services and providers. (effective 07/01/2020) **CFR § 441.540, Person-centered service plan (a)(6) (effective 01/03/2017 & 03/11/2024):** Person-centered planning process. The person-centered planning process is driven by the individual. The process …. Offers choices to the individual regarding the services and supports they receive and from whom. Includes a method for the individual to request updates to the plan. Records the alternative home and community-based settings that were considered by the individual. **§1915(i) State Plan HCBS, Person-Centered Planning & Service Delivery (7) Informed Choice of Providers (effective 03/01/2020):** The information reviewed with the recipient/personal representative include: process for development of the POC, services to be provided, and choice of service provider. The recipient may request a change in services or service provider at any time. **MSM Chapter 1800, Section 1803.1B(7) (effective 03/01/2020 & 02/01/2023):** The provider must also ensure the recipient, or the recipient's designated representative, is fully involved in the treatment planning process which is documented on the Service Plan.
14) SP addresses needs identified on the POC.	**Quality Improvement Sub requirement 1-a (effective 07/01/2020):** The state must demonstrate that service plans address assessed needs of 1915(i) participants. **§1915(i) State Plan HCBS, Person-Centered Planning & Service Delivery (6) Supporting the Participant in Development of Person-Centered Plan (effective 03/01/2020):** A POC form must be developed for all potential recipients. The POC includes, at a minimum, the individual's needs. **MSM Chapter 1800, Section 1803.1B(7) (effective 03/01/2020):** The service plan is developed by the provider using the 1915(i) HCBS Plan of Care (POC) and includes the identified needs from the POC. The service plan must include the description of services and amount of time (hourly, daily, weekly). The provider must also ensure the recipient, or the recipient's designated representative, is fully involved in the treatment planning process which is documented on the Service Plan. **MSM Chapter 1800, Section 1803.1B(7) (effective 02/01/2023):** The Service Plan (SP) is developed by the provider using the 1915(i) HCBS Plan of Care (POC). At the minimum, a provider's SP must include: the description of services, duration and amount of time (hourly, daily, weekly). The provider must also ensure the recipient, or the recipient's designated representative, is fully involved in the person-centered planning process which is documented on the SP.

	DHCFP PLAN OF CARE (POC)
15) Was there a DHCFP POC.	**§1915(i) State Plan HCBS, Person-Centered Planning & Service Delivery (6) Supporting the Participant in Development of Person-Centered (effective 03/01/2020)** The SMA HCC is responsible for the development of Plan of Care (POC) using a person-centered plan. **MSM Chapter 1800, Section 1803.6B (effective 03/01/2020):** For applicants determined eligible for 1915(i) services, a person-centered POC will be developed that includes, at a minimum, the individual's needs, goals to meet those needs, identified risks and services to be provided. **MSM Chapter 1800, Section 1803.6C (effective 02/01/2023):** Once an applicant or recipient is determined eligible for 1915(i) services, a person-centered POC will be developed that includes, at a minimum, the individual's needs, goals to meet those needs, identified risks and services to be provided.
16) POC addresses assessed needs identified on SHA.	**Quality Improvement Sub Requirement 1-a (effective 07/01/2020):** The state must demonstrate that service plans address assessed needs of 1915(i) participants. **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. **§1915(i) State Plan HCBS, Person-Centered Planning & Service Delivery (6) Supporting the Participant in Development of Person-Centered Plan (effective 03/01/2020):** A POC form must be developed for all potential recipients. The POC includes, at a minimum, the individual's needs. **MSM Chapter 1800, Section 1803.6B(2) (effective 03/01/2020)** **MSM Chapter 1800, Section 1803.6C(2) (effective 02/01/2023):** The POC is person-centered, based on personalized goals, needs, preferences and developed with participation from the recipient, the family, the designated representative, and anyone else the recipient chooses. The Health Care Coordinator (HCC) documents this information in the SHA narrative.
17) 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 rep 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)(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 (8) Process of Making Person-Centered Service Plan to Approval of the Medicaid Agency (effective 03/01/2020):** The POC is developed and implemented by the SMA HCC using a person-centered process. The HCC contacts all service providers to arrange for the agreed upon services. **MSM Chapter 1800, Section 1803.6C (effective 03/01/2020 & 02/01/2023):** Once an applicant or recipient is determined eligible for 1915(i) services, a person-centered POC will be developed that includes, at a minimum, the individual's needs, goals to meet those needs, identified risks, and services to be provided.

a) Residence chosen by recipient. (effective 03/17/2023)	**CFR § 441.725, Person-Centered Service Plan (b)(1) (effective 01/03/2017 & 03/11/2024):** Reflect that the setting in which the individual resides is chosen by the individual. The State must ensure that the setting chosen by the individual is integrated in.
b) Opportunities to access community/ employment. (effective 03/17/2023)	**CFR § 441.725, Person-Centered Service Plan (b)(1) (effective 01/03/2017 & 03/11/2024):** Supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS. **§1915(i) State Plan HCBS: Person-Centered Planning & Service Delivery (6) (effective 03/01/2020):** Planning includes community integration and opportunities to participate in integrated settings/seek employment or volunteer activities.
c) Reflects strengths and preferences. (effective 03/17/2023)	**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, Person-Centered Planning & Service Delivery (6) Supporting the Participant in Development of Person-Centered Plan (effective 03/01/2020):** Planning includes dentification of what is important to and for the individual and personal preferences.
d) POC identifies the personalized goals of the POC.	**CFR § 441.725, Person-Centered Service Plan (b)(4) (effective 01/03/2017 & 03/11/2024):** Include individually identified goals and desired outcomes. **CFR § 441.725, Person-Centered Service Plan (b)(5) (effective 01/03/2017 & 03/11/2024):** Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of State plan HCBS. **§1915(i) State Plan HCBS, Person-Centered Planning & Service Delivery (6) Supporting the Participant in Development of Person-Centered Plan (effective 03/01/2020):** The POC includes, at a minimum, the individual's needs, goals to meet those needs, identified risks and services to be provided. **MSM Chapter 1800, Section 1803.6B(4) (effective 03/01/2020):** The personalized goals are identified by the recipient and documented in the initial POC and each time the POC is updated with information obtained during the contacts with the recipient. **MSM Chapter 1800, Section 1803.6C(2) (effective 02/01/2023):** The personalized goals are identified by the recipient and documented in the POC and each time the POC is updated with information obtained during the contacts with the recipient.
e) Reflects risk factors.	**CFR § 441.725, Person-Centered Service Plan (b)(6) (effective 01/03/2017 & 03/11/2024):** Reflect risk factors and measures in place to minimize them. **§1915(i) State Plan HCBS, Person-Centered Planning & Service Delivery (6) Supporting the Participant in Development of Person-Centered Plan (effective 03/01/2020):** The POC includes, at a minimum, the individual's needs, goals to meet those needs, identified risks and services to be provided. **MSM Chapter 1800, Section 1803.6B (effective 03/01/2020)** **MSM Chapter 1800, Section 1803.6C(4) (effective 02/01/2023):** The POC development process considers risk factors, equipment needs, behavioral status, current support system and unmet service needs (this list is not all inclusive).
f) POC is understandable. (effective 03/17/2023)	**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 (6) Supporting the Participant in Development of Person-Centered Plan (effective 03/01/2020): Planning includes use of plain language.
g) Recipient's back up plan/strategies. (effective 03/17/2023)	**CFR § 441.725, Person-Centered Service Plan (b)(6) (effective 01/03/2017 & 03/11/2024):** Reflect individualized back-up plans and strategies when needed.
18) POC was updated annually or more frequently as needed.	**Quality Improvement Sub Requirement 1-b (effective 07/01/2020):** Quality Measure Plan of Care are updated annually. **§1915(i) State Plan HCBS, Person-Centered Planning & Service Delivery (3) (effective 03/01/2020):** 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 1800, Section 1803.6C(1)(a) (effective 03/01/2020):** 1. Once a recipient is authorized for 1915(i) program services, that authorization period is for 12-months from the date of authorization. a. Prior to the 12-month authorization period ending, the Health Care Coordinator will contact the recipient within 30 days to initiate a re-evaluation. The re-evaluation includes a face-to-face assessment to determine whether the recipient continues to meet needs-based criteria. The POC will be updated during the re-evaluation assessment and the recipient/designated representative will receive a copy of the POC which must be signed. **MSM Chapter 1800, Section 1803.6A (2)(a) & (b) (effective 02/01/2023):** Once a recipient is authorized for 1915(i) services, that authorization period is for 12-months from the date of authorization. a. Prior to the 12-month authorization period ending, the HCC will contact the recipient within 30 days to initiate a re-evaluation. The re-evaluation includes a face-to-face assessment or via telehealth under certain circumstances, to determine whether the recipient meets the needs-based criteria. b. If a recipient has a change in condition during the authorization period, the HCC will contact the recipient/designated representative to discuss the changes and update the POC, as applicable.
19) Frequency/ Duration/Scope of each service was identified.	**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, Adult Day Health Care, Day Habilitation and Residential Habilitation (effective 03/01/2020):** The amount, frequency and duration of this service is based on the participant's assessed needs and documented in the approved POC. **MSM Chapter 1800, Section 1803.6B(6) (effective 03/01/2020):** **MSM Chapter 1800, Section 1803.6C(6) (effective 02/01/2023):** The POC identifies the services required, including type, scope, amount, duration and frequency of services.
20) POC signed by recipient/designated rep with documentation. (effective 07/01/2020) **POC signed by recipient/designated rep with documentation within 60 days of date of assessment. (effective 02/01/2023)**	**CFR § 441.725, Person-Centered Service Plan (b)(9) (effective 01/03/2017 & 03/11/2024):** 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. **MSM Chapter 1800, Section 1803.6B(7) (effective 03/01/2020):** A recipient will receive a copy of the initial POC which must be signed within 60 calendar days of the date of the Statement of Understanding (SOU). If the recipient signature cannot be obtained due to extenuating circumstances, services can commence with verbal approval from the recipient. The Health Care Coordinator documents the recipient's verbal approval in the SHA narrative and obtains the signature and date on the finalized POC. On going Recipients: Once a recipient is authorized for 1915(i) program services, that authorization period is for 12-months from the date of authorization. a. Prior to the 12-month authorization period ending, the Health Care Coordinator will contact the recipient within 30 days to initiate a re-evaluation. The re-evaluation includes a face-to-face assessment to determine whether the recipient continues to meet needs-based criteria. The POC will be updated during the re-evaluation assessment and the recipient/designated representative will receive a copy of the POC which must be signed. **MSM Chapter 1800, Section 1803.6C(7)(a) & (b) & (c) (effective 02/01/2023):** A recipient will receive a copy of the POC which must be signed within 60 calendar days of the date of assessment.

	a. If the recipient signature cannot be obtained due to extenuating circumstances, services can commence with verbal approval from the recipient. b. The HCC shall document the recipient's verbal approval in the SHA narrative and obtain the signature and date on the finalized POC. c. If the recipient authorizes an individual to be their designated representative, then the Designated Representative Attestation form must be completed and signed.
21) POC signed by HCC & provider signed within 60 days of POC date. (effective 07/01/2020) **POC signed by service providers within 60 calendar days of the POC start date. (effective 02/01/2023)**	**MSM Chapter 1800, Section 1803.6B(8) (effective 07/01/2020):** The provider must also sign and date a copy of all new, or a reported change, POCs within 60 calendar days. The Health Care Coordinator ensures the provider returns a signed copy of the POC for the case file. **MSM Chapter 1800, Section 1803.6C(8) (effective 02/01/2023)** The service providers are given a copy of the recipient's POC which must be signed and dated within 60 calendar days of the POC start date. The HCC ensures the provider returns a signed copy of the POC and Service Plan for the case file.
22) POC updated when changes to the recipient occur during authorization period.	**CFR § 441.725, Person-Centered Service Plan (c) (effective 01/03/2017 & 03/11/2024):** Reviewing the person-centered service plan. 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, Person-Centered Planning & Service Delivery (3) (effective 03/01/2020):** 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 1800, Section 1803.6C(2) (effective 07/01/2020):** If a recipient has a change in condition during the authorization period, the Health Care Coordinator will conduct a visit to update the POC with the recipient/designated representative. A copy of the signed, updated POC will be provided to the recipient and service provider. **MSM Chapter1800, Section 1803.6A(2)(b) (effective 02/01/2023):** If a recipient has a change in condition during the authorization period, the HCC will contact the recipient/designated representative to discuss the changes and update the POC, as applicable.
23) Recipient signature indicating received information & contact list for reporting critical incidences at initial and annual assessments.	**§1915(i) State Plan HCBS, Person-Centered Planning & Service Delivery (6) Supporting the Participant in Development of Person-Centered Service Plan (effective 03/01/2020):** During the initial assessment, and development of the person-centered POC, the potential recipient, family, support systems, and/or designated representatives are encouraged to participate in the development of the POC and to direct the process to the maximum extent possible. The person-centered planning process is driven by the individual, designated representative, legal guardian or other supports chosen by the individual and includes necessary information and support to ensure that the individual directs the process to the maximum extent possible.
24) SOU signed by recipient acknowledging they had the right to choose the services and providers at initial assessment/annually. (effective 07/01/2020) **25) SOC signed by recipient/designated rep acknowledging**	**§1915(i) State Plan HCBS, Person-Centered Planning & Service Delivery (7) Informed Choice of Providers (effective 03/01/2020):** During the assessment process, and at any time during the authorization period, the SMA HCC informs and provides a printed list of qualified providers to the potential recipient so they may choose among enrolled providers. All potential recipients must read, or have the form read to them, and sign the Statement of Understanding in which the potential recipient acknowledges a selection from the qualified providers on either a printed list or via the SMA website. The information reviewed with the recipient/personal representatives include: process for development of the POC, services to be provided, and choice of service provider. The recipient may request a change in services or service provider at any time. **MSM Chapter 1800, Section 1803.6B(5) (effective 03/01/2020):** Facilitation of individual's choice regarding services and supports and who provides the services is given during the initial assessment. The recipient must sign the Statement of Understanding (SOU) acknowledging they had the right to choose the services and providers. **MSM Chapter 1800, Section 1803.6C(5) (effective 02/01/2023):**

the right to choose the services and providers at initial assessment/annually. (effective 02/01/2023)	Facilitation of individual's choice regarding services and supports and who provides the services is given during the assessment. The recipient must sign the Statement of Choice (SOC) they had the right to choose the services and providers.
FINANCIAL REVIEW REQUIREMENTS	
Quality Improvement Sub Requirement, NAC, CFR, State Plan, MSM	
	ELIGIBILITY
Enrollee eligible on the date of service.	**CFR § 441.720 Independent assessment, (a) (effective 01/03/2017 & 03/11/2024):** Requirements. For each individual determined to be eligible for the State plan HCBS benefit, the State must provide for an independent assessment of needs, which may include the results of a standardized functional needs assessment, in order to establish a service plan. **§1915(i) State Plan HCBS, Evaluation/Reevaluation of Eligibility (5) Needs-based HCBS Eligibility Criteria (eff. 03/01/2020):** A recipient must need assistance or prompting in at least two Activities of Daily Living (bathing, dressing, grooming, toileting, transfer, mobility, eating) and must also have one of the following risk factors: At risk of social isolation due to lack of family or social supports. At risk of a chronic medical condition being exacerbated if not supervised by a registered nurse; or A history of aggressive behavior if not supervised or if medication is not administered by a registered nurse. **MSM Chapter 1800, Section 1803.1B(2) (effective 03/01/2020 & 02/01/2023)** 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 1800, Section 1803.1A(1)(a-d) (effective 03/01/2020 & 02/01/2023):** PROGRAM ELIGIBILITY a. An individual must meet and maintain Medicaid eligibility. b. An individual must be 18 years of age or older. c. An individual must meet the needs-based eligibility requirements. d. The individual must reside in the community. **MSM Chapter 1800, Section 1803.1(eff. 03/01/2020 & 02/01/2023):** The DHCFP 1915(i) Home and Community-Based Services (HCBS) State Plan Option utilizes a needs-based criteria to evaluate and reevaluate whether an individual is eligible for services. The criteria considers the individual's support needs and risk factors. In order to be eligible, a recipient must need assistance or prompting in at least two Activities of Daily Living (ADL) which includes bathing, dressing, grooming, toileting, transfer, mobility, eating and must also have one of the following risk factors: 1. At risk of social isolation due to lack of family or social supports; 2. At risk of a chronic medical condition being exacerbated if not supervised by a registered nurse (RN); or 3. A history of aggressive behavior if not supervised or if medication is not administered by an RN. The DHCFP Health Care Coordinator (HCC) conducts the needs-based eligibility determinations. 2. Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i)

	services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility is applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS. **MSM Chapter 1800, Section 1803.1A(2)(b):** Day Treatment Program-Day habilitation-targeted to individuals with Traumatic Brian Injury (TBI) or Acquired Brain Injury (ABI). **MSM Chapter 1800, Section 1803.1A(2)(c):** Residential Habilitation Program-Residential Habilitation-targeted to individuals with TBI or ABI.
Are there any conflicting services provided during the review month/service dates (Institutional care).	**§1915(i) State Plan (HCBS), Administration and Operation (8) Non-duplication of services (effective 03/01/2020):** 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 1800, Section 1803.1A(3)(a-e) (effective 03/01/2020 & 02/01/2023):** The following services are not covered benefits under the 1915(i) HCBS State Plan Option and are therefore not reimbursable: a. Services provided to an individual who is not eligible for Nevada Medicaid. b. Services rendered to a recipient who no longer meets the needs-based eligibility criteria. c. Services rendered to a recipient who is no longer in the community setting but is institutionalized (hospital, nursing facility, correction or Intermediate Care Facility (ICF) for intellectual or developmental disabilities). d. A recipient who resides in a residential setting such as group home, assisted living or other type of residential facility where a per diem rate is paid for 24-hour care is not eligible. e. For Day Habilitation or Residential Habilitation, services provided to an individual who does not have a TBI or ABI diagnosis. **MSM Chapter 1800, Section 1803.4 (effective 03/01/2020 & 02/01/2023):** Day Habilitation services are activities scheduled on a regular basis, a minimum of one day per week. These services are provided in a non-residential setting, separate from the recipient's private residence or other residential living arrangement. Services include assistance with the acquisition, retention or improvement in self-help, socialization and adaptive skills that enhance social development and develop skills in performing ADL and community living.
	PRIOR AUTHORIZATION
Is service prior authorized.	**MSM Chapter 1800, Section 1803.6B(9) (effective 03/01/2020):** ADHC-Services must be prior authorized. If a PA is required, it is the DHCFP Health Care Coordinators are responsible for prior authorizing 1915(i) services. **MSM Chapter 1800, Section 1803.6A(2) (effective 02/01/2023):** Once a recipient is authorized for 1915(i) services, that authorization period is for 12-months from the date of authorization. **MSM Chapter 100 Medicaid Program, Section 103.2(D) (effective 08/28/2019 & 04/26/2023):** If a PA is required, it is the responsibility of the provider to request before providing services. **MSM Chapter 3300 Program Integrity, Section 3303.3A(2)(l)(1) (effective 05/01/2019):** Requirement for all services to be prior authorized to be eligible for reimbursement.
	CLAIMS
Procedure code correct.	**§1915(i) State Plan (HCBS), Methods and Standards for Establishing Payment Rates (1) Rate Methodology (03/05/2024):** 7. Fixed hourly rate is scaled to the proper unit based on the procedure code. **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.	**MSM Chapter 1800, Section 1803.6B(6) (eff. 03/01/2020)** **MSM Chapter 1800, Section 1803.6C(6) (eff. 02/01/2023)** The POC identifies the services required, including type, scope, amount, duration and frequency of services. **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.
	DAILY RECORD
Services provided on nursing logs match the POC.	**MSM Chapter 1800, Section 1803.3B(2)(d) (effective03/01/2020):** Day Habilitation: The provider must have documentation of daily attendance and notes that indicate the health components of this service which is maintained and may be used to review claims paid. This documentation is verification of service provision and may be used to review claims paid. The delivery of specific services required by the POC and outlined in the Service Plan must be documented in the daily records. **MSM Chapter 1800, Section 1803.5B(2) (effective 03/01/2020):** Residential Habilitation: The provider must have documentation of daily attendance and notes that indicate the health components of this service which is maintained and may be used to review claims paid. This documentation is verification of service provision and may be used to review claims paid. The delivery of specific services required by the POC and outlined in the Service Plan must be documented in the daily records. **MSM Chapter 1800, Section 1803.3B(3)(b) (effective 02/01/2023):** The delivery of specific services required by the POC and outlined in the SP, must be documented in the nursing log. **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 on nursing logs 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, Day Habilitation, Residential Habilitation and Residential Habilitation (effective 07/01/2020):** Specify limits (if any) on the amount, duration, or scope of this service.

	MSM Chapter 1800, Section 1803.6B(6) (effective 03/01/2020): **MSM Chapter 1800, Section 1803.6C(6) (effective 02/01/2023):** The POC identifies the services required, including type, scope, amount, duration and frequency of services.
Service units/days provided match the 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.
Daily attendance signed by recipient.	**MSM Chapter 1800, Section 1803.2(c) (effective 03/01/2020)** **MSM Chapter 1800, Section 1803.2(D) (effective 02/01/2023):** Initial and/or sign the provider service documentation logs as applicable, verifying services were rendered unless otherwise unable to perform this task due to cognitive and/or physical limitations. **MSM Chapter 1800, Section 1803.3B(2)(d) (effective 03/01/2020):** The recipient and a center staff member must sign each record. If the recipient is unable to provide a signature due to cognitive and/or physical limitation, this must be clearly documented in the recipient file. A designated representative may sign on behalf of the recipient. The center may create a signature page which can encompass a recipient signature for the Service Plan and any other signature requirements. **MSM Chapter 1800, Section 1803.4B(2)(c)(1-2) (effective 03/01/2023):** The recipient and the appropriate staff member must sign or initial each record. The appropriate staff member would include, but not limited to: Director of the facility or designated acting Director. In addition to a provider's SP, the recipient must also sign or initial the attendance log.
Daily attendance & nursing/daily log signed by provider staff.	**MSM Chapter 1800, Section 1803.3B(2)(d) (effective 03/01/2020):** The recipient and a center staff member must sign each record. If the recipient is unable to provide a signature due to cognitive and/or physical limitation, this must be clearly documented in the recipient file. A designated representative may sign on behalf of the recipient. **MSM Chapter 1800, Section 1803.3B(3)(b)(2) (effective 02/01/2023):** An appropriate provider staff member must sign and date nursing log on a monthly basis indicating services were provided.
If applicable, documented by CM recipient is unable to sign due to cognitive &/or physical limitations (cannot be signed by provider).	**MSM Chapter 1800, Section 1803.2B(2)(d) (effective 03/01/2020):** The recipient and a center staff member must sign each record. If the recipient is unable to provide a signature due to cognitive and/or physical limitation, this must be clearly documented in the recipient file. A designated representative may sign on behalf of the recipient. **MSM Chapter 1800, Section 1803.4B(2)(c)(3) (effective 03/01/2023):** If the recipient is unable to provide a signature due to cognitive and/or physical limitation, this must be clearly documented in the recipient's file. A designated representative may sign on behalf of the recipient as referenced in 1803.6C(7)(c). The facility may create a signature page which a designated representative should sign on behalf of the recipient signature for the SP and any other signature requirements.
If applicable, provider submitted signature page.	**MSM Chapter 1800, Section 1803.3B (2)(d) (effective 03/01/2020):** The center may create a signature page which can encompass a recipient signature for the Service Plan and any other signature requirements. **MSM Chapter 1800, Section 1803.4B(2)(c)(4) (effective 03/01/2023):** The facility may create a signature page which a designated representative should sign on behalf of the recipient signature for the SP and any other signature requirements.
	PAYMENTS

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 allowable 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 payments 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.	**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
Provider eligible for payment (active) at time-of-service provision.	**MSM Chapter 1800, Section 1803.1B(1) (effective 03/01/2020 & 02/01/2023)** In addition to this chapter, providers must also comply with rules and regulations for providers as set forth in the MSM Chapter 100. Each 1915(i) service outlines specific provider qualifications which must be adhered to in order to render that 1915(i) service. **MSM Chapter 1800, Section 1803.3B(1) (effective 03/01/2020 & 02/01/2023)** Each provider of ADHC services must obtain and maintain licensure as required in the 1915(i) State Plan and NAC Chapter 449. Furthermore, providers must adhere to

	all requirements of NAC 449 as applicable to licensure. **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) ADHC & HBHS

ABI- (ACQUIRED BRAIN INJURY)
Refers to impaired brain functioning due to a medically verifiable incident including, but not limited to: 1. a cerebral vascular accident; 2. a ruptured aneurysm; 3. anoxia; or 4. hypoxia and brain tumors. Not all acquired brain injuries require or meet criteria for comprehensive rehabilitation services**.**

ADHC- (ADULT DAY HEALTH CARE)
An organized program of services during the day in a group setting for the purpose of supporting the personal independence of older adults and promoting their social, physical, and emotional well-being.

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

ADSD- (AGING AND DISABILITY SERVICES DIVISION)
A state agency that is part of Nevada's Department of Health and Human Services (DHHS) and is the operating agency of the Home and Community Based Services (HCBS) Waivers for the Frail Elderly, Physically Disabled, and Individuals with Intellectual Disabilities.

ALiS- (ONLINE PROVIDER REVIEW SYSTEM)
The Online Provider Review System (ALiS) allows users to schedule, complete, and provide results of an annual inspection for Nevada Medicaid's Home and Community Based Services (HCBS) providers.

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.

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.

DHCFP- (DIVISION OF HEALTH CARE FINANCING AND POLICY)
A state agency that is part of Nevada's Department of Health and Human Services (DHHS) that works in partnership with the Centers for Medicare & Medicaid Services (CMS) to assist in providing quality medical care for eligible individuals and families with low incomes and limited resources.

DME- (DURABLE MEDICAL EQUIPMENT)
Medically necessary durable medical equipment that a doctor prescribes for use in the home.

FE- (HCBS WAIVER FOR THE FRAIL ELDERLY)
A 1915(c) Waiver Program (formerly Community Home Base Initiative Program) that provides the option of home and community-based services as an alternative to institutional nursing facility care and allows for maximum independence for the frail elderly who would otherwise need institutional nursing facility services.

FPL- (FEDERAL POVERTY LEVEL)
The federal poverty level (FPL) is an economic measure used to decide whether the income level of an individual or family qualifies them for certain federal benefits and programs.

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.

HCC- (HEALTH CARE COORDINATOR)
Health care coordinators, also called medical or health service managers, oversee the organizational aspects of patient care in healthcare organizations.

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

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

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

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

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

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

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

LRI- (LEGALLY RESPONSIBLE INDIVIDUAL)
Individuals who are legally responsible to provide medical support including: spouses of recipients, legal guardians, and parents of minor recipients, including: stepparents, foster parents, and adoptive parents.

LTSS- (LONG TERM SERVICES AND SUPPORTS)
A unit within the Division of Health Care Financing and Policy that provides services specifically to Medicaid eligible recipients. This includes services for a diverse group of Nevadans including the elderly and people living with disabilities and special health care needs. LTSS provides both institutional and home and community-based 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.

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.

PCS- (PERSONAL CARE SERVICES)
Hands-on assistance with activities of daily living (ADLs) (such as eating, bathing, dressing, and bladder and bowel requirements) or instrumental activities of daily living (IADLs) (such as taking medications and shopping for groceries).

PD- (HCBS WAIVER SERVING PEOPLE WITH PHYSICAL DISABILITIES)
A 1915(c) Waiver Program that provides the option of home and community-based services as an alternative to institutional nursing facility care and allows for maximum independence for persons with physical disabilities who would otherwise need institutional nursing facility services.

PERS- (PERSONAL EMERGENCY RESPONSE SYSTEM)
An electronic device which enables certain recipients at high risk of institutionalization to secure help in an emergency. The recipient may also wear a portable "help" button to allow for mobility. The system is connected to a landline and programmed to signal a response center once the "help" button is activated.

PES- (PARTICIPANT EXPERIENCE SURVEY)
The Participant Experience Survey (PES) is an interview tool developed by MEDSTAT under a contract from the CMS. The survey captures data that can be used to calculate indicators for monitoring quality within the HCBS programs.

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

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

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

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

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

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

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.

SAMS- (SOCIAL ASSISTANCE MANAGEMENT SOFTWARE)
Social Assistance Management Software or SAMS® manages consumer (recipient) and service data for social assistance organizations.

SC- (SERVICE COORDINATOR)
Responsible for monitoring and documenting the provision of waiver services, as well as recipient health and welfare. The Developmental Specialist or Psychiatric Caseworker qualified by educational background or training to assist, advise, direct, and oversee services to eligible individuals.

SHA- (SOCIAL HEALTH ASSESSMENT)
An assessment 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.

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

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

SP- (SERVICE PLAN)
Health care service plan means a plan that undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees.

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.

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.

TBI- (TRAUMATIC BRAIN INJURY)
A traumatic brain injury is a medically verifiable incident of the brain not of a degenerative or cognitive nature, but caused by an external force, that may produce a diminished or altered state of consciousness, which results in an impairment of cognitive abilities or functioning. It can also result in a disturbance of behavioral or emotional functioning. These impairments may be either temporary or permanent and can cause partial or total functional disability or psychosocial maladjustment.

TCM- (TARGETED CASE MANAGEMENT)
Targeted case management is case management services provided only to specific classes of individuals, or to individuals who reside in specific areas of the state (or both). Presently, Nevada State Medicaid has "targeted" case management services to specific classes of individuals.

UNA- (UNIVERSAL NEEDS ASSESSMENT)
Universal Needs Assessment is a tool for 1915(i) Services used to determine whether a recipient is eligible for 1915(i) services through Nevada Medicaid. Assessment must be performed face-to-face by the recipient's physician who is an independent third party.