MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

February 25, 2020

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: CODY L. PHINNEY, DEPUTY ADMINISTRATOR /Cody L. Phinney/

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1800 – 1915(i) HCBS STATE PLAN OPTION
ADULT DAY HEALTH CARE AND HABILITATION

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 1800 – Adult Day Health Care (ADHC) are being proposed to encompass all 1915(i) services in one MSM. Changing the name of MSM 1800 – Adult Day Health Care to 1915(i) – Home and Community Based State Plan Option Adult Day Health Care and Habilitation Services. Addition of federal regulations to become in compliance and necessary changes to be aligned with concurrent state plan amendment changes. Throughout, language specific to Adult Day Health Care were replaced with general 1915(i) requirements and the ADHC service was moved further in the chapter with the addition of two other 1915(i) services combined from MSM 2400.

Throughout the chapter, grammar, punctuation and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and rearranging of sections was necessary.

Entities Financially Affected: This proposed change affects all Medicaid-enrolled provides delivering Adult Day Health Care Services. Those Provider Types (PT) include Adult Day Health Care services (PT 39) and Habilitation services (PT 55).

Financial Impact on Local Government: There is no anticipated fiscal impact known at this time.

These changes are effective March 1, 2020.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 07/20 CHAPTER 1800 – 1915(i) HCBS STATE PLAN OPTION ADULT DAY HEALTH CARE AND HABILITATION	MTL 15/12, 18/13 CHAPTER 1800 – ADULT DAY HEALTH CARE

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1800	**INTRODUCTION**	Deleted language related to Adult Day Health Care. Language added regarding "Section 1915(i) of the Social Security Act (SSA) and eligibility differences between 1915(c) waivers. Language was updated and/or reworded for improved readability and clarity.
1801	**AUTHORITY**	Moved language related to ADHC from this section. Added language regarding Section 1915(i) of the Social Security Act "(1)(a) through (j)." Added new language for Code of Federal Regulations (CFR) "42 CFR 441.710; 441.715, 441.720, 441.725 and 441.730."
1803.1	**ADULT DAY HEALTH CARE (ADHC) SERVICES**	Renamed to "NEEDS-BASED ELIGIBLITY CRITERIA." Added language regarding criteria for needs-based eligibility and whom conducts the eligibility determinations.
1803.1A(1)	**COVERAGE AND LIMITATIONS**	Replaced "Eligible Recipients" with "Program Eligibility." Removed reference to "Physician's Evaluation." Removed language for "Eligible Providers" and moved language for "Transportation."
1803.1A(2)	**COVERED SERVICES**	Added new section for "Covered Services" and defined services as "Adult Day Health Care, Day Habilitation and Residential Habilitation."
1803.1A(3)	**NON-COVERED SERVICES**	Added new section for "Non-Covered Services" and language was updated and/or reworded for improved for readability and clarity.
1803.1B	**PROVIDER RESPONSIBILITIES**	Replaced subsection title "Medicaid Contract Requirements" with "Provider Qualifications." Added subsections and language related to "Medicaid Eligibility," "Direct Marketing" and "Serious Occurrence Reports." Language moved to this section regarding "HIPAA, Privacy and Confidentiality," "Service Plan" and "Training Requirements." Removed language related to "Criminal Background Checks," "Tuberculosis Testing," language was updated and/or reworded for improved readability and clarity.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1803.4	**RECIPIENT RESPONSIBILITIES**	Added language regarding individuals receiving 1915(i) services are "entitled to privacy, to be treated with respect and free from coercion and restraint." Additional language included that recipients or a designated representative must adhere to certain requirements.
1803.5	**ADHC SERVICES**	Moved language from previous Section 1803.1 to this section.
1803.5A	**COVERAGE AND LIMITATIONS**	Added new section title "COVERAGE AND LIMITATIONS" and included language moved from Section 1803.1.
1803.5B	**PROVIDER RESPONSIBILITIES**	Added new section "Provider Responsibilities" including subsection for "Provider Qualifications" for ADHC services. Added language regarding experience working with "individuals with a history of aggressive behavior" under Staffing Requirements. Deleted language for "Physician Evaluation" and "Universal Needs Assessment." Moved Service Plan to Section 1803.1B. Deleted language regarding "Plan of Care." Clarified language under "Attendance Record and Nursing Notes." Deleted language for "Employee Record Requirements," "Recipient Record Requirements," "Confidentiality and Release of Recipient Records" and "Provider Liability." Moved language for "NOTIFICATION OF SUSPECTED ABUSE AND NEGLECT" and "HIPAA, PRIVACY AND CONFIDENTIALITY." Deleted language for "RECIPIENT RESPONSIBILITIES."
1803.6	**DAY HABILITATION**	Added new section for "Day Habilitation" services explaining the services included.
1803.6A	**COVERAGE AND LIMITATIONS**	New section with language that Day Habilitation Services are targeted to individuals with a Traumatic Brain Injury (TBI) or Acquired Brain Injury (ABI).

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1803.7	**RESIDENTIAL HABILITATION**	Added new section for "Residential Habilitation" services explaining the services included.
1803.7A	**COVERAGE AND LIMITATIONS**	New section with language for Residential Habilitation Services are targeted to individuals with a Traumatic Brain Injury (TBI) or Acquired Brain Injury (ABI).
1803.7B	**PROVIDER RESPONSIBILITIES**	Added new section "Provider Responsibilities" including subsection for "Provider Qualifications" for Residential Habilitation services.
1803.8	**INTAKE AND ONGOING PROCOEDURES**	Added new section and language for Intake and Ongoing Procedures. New subsections for "Referral" including process for applying for 1915(i) services, subsection "Person-Centered Plan of Care" detailing the process for developing a Person-Centered Plan of Care and subsection "Ongoing Procedures" detailing process for retaining services.
1803.1E	**PRIOR AUTHORIZATION AND BILLING**	Deleted language regarding "Prior Authorization Procedure" and "Provider Billing."
1803.09	**TERMINATION OF 1915(i) SERVICES**	New section added with language regarding the "Termination of 1915(i) Services" including details on the basis for denials to terminate from 1915(i) services.
1804	**RATES AND REIMBURSMENT**	Added new section for "Rates and Reimbursement" and reference to billing guide and reimbursement code.
1805	**QUALITY ASSURANCE**	Renumbered to 1805 from 1804 and clarified language. Removed language referring to ADHC and provider reviews. Updated language to referral to "Quality Improvement Strategy outlined in the 1915(i) HCBS State Plan." Language was updated and /or reworded for improved readability and clarify.
1806	**TRANSPORTATION**	Renumbered and moved section from 1803.1A(3) to this new section. Language was

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		updated and /or reworded for improved readability and clarify.
1807	**HEARINGS**	Renumbered and language was updated and/or reworded for improved readability and clarity.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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1915(i) HCBS STATE PLAN OPTION ADULT DAY HEALTH CARE AND HABILITATION

1800 INTRODUCTION

Under Section 1915(i) of the Social Security Act (SSA) states can provide Home and Community-Based Services (HCBS) to individuals who require less than institutional level of care and therefore would otherwise not be eligible for such services through an 1915(c) HCBS Waiver.

Specifically, Section 1915(i) of the Act allows the Nevada Division of Health Care Financing and Policy (DHCFP) to provide State Plan HCBS similar to that of a 1915(c) HCBS Waiver using a needs-based eligibility criterion rather than an institutional level of care criteria. Additionally, a 1915(i) HCBS State Plan Option has no cost neutrality requirement as required under a 1915(c) HCBS Waiver. This significant distinction affords the Nevada DHCFP the opportunity to offer HCBS to recipients whose needs are substantial, but are not severe enough to qualify them for institutional or waiver services.

1801 AUTHORITY

Section 6086 of the Deficit Reduction Act, added Section 1915(i) to the SSA, allowing states the option to offer home and community-based services previously only available through a traditional 1915(c) Waiver.

Statutes and Regulations:

- Social Security Act: 1915(i) (1)(a) through (j)
- Code of Federal Regulations (CFR)
  - 42 CFR 441.710 State Plan Home and Community-Based Services under Section 1915(i)(1) of the Act
  - 42 CFR 441.715 Needs-Based Criteria and Evaluation
  - 42 CFR 441.720 Independent Assessment
  - 42 CFR 441.725 Person-Centered Service Plan
  - 42 CFR 441.730 Provider Qualifications
- Nevada Revised Statutes (NRS) Chapter 449
- Nevada Administrative Code (NAC) Chapter 449

1802 RESERVED

1803 POLICY

1803.1 NEEDS-BASED ELIGIBILITY CRITERIA

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.

1803.1A COVERAGE AND LIMITATIONS

1. 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.

2. COVERED SERVICES

a. Adult Day Health Care.

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.

3. NON-COVERED SERVICES

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. For Adult Day Health Care (ADHC), 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 for ADHC services.

e. For Day Habilitation or Residential Habilitation, services provided to an individual who does not have a TBI or ABI diagnosis.

1803.1B PROVIDER RESPONSIBILITIES

1. PROVIDER QUALIFICATION

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.

2. MEDICAID ELIGIBLITY

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.

3. DIRECT MARKETING

Providers shall not engage in any unsolicited direct marketing practices with any current or potential Medicaid 1915(i) recipient. Providers may not, directly or indirectly, engage in door-to-door, telephone, direct mail, email or other type of cold-call marketing activities. All marketing activities must be limited to the general education about the benefits of

1915(i) services.

Marketing material must be accurate and not mislead, confuse or defraud current or potential recipients. Statements considered inaccurate, false or misleading include, but are not limited to, any assertion or statement that:

a. The recipient must enroll with a specific provider in order to obtain benefits or in order to not lose benefits; or

b. The provider is endorsed, certified or licensed by the DHCFP.

Additionally, compensation or incentive of any kind which encourage a recipient to transfer from one provider to another is strictly prohibited.

4. HIPAA, PRIVACY AND CONFIDENTIALITY

Refer to MSM Chapter 100 for information on HIPAA, privacy and confidentiality of recipient records and other Protected Health Information (PHI).

5. NOTIFICATION OF SUSPECTED ABUSE OR NEGLECT

State law requires that persons employed in certain capacities must make a report to the appropriate agency immediately, but in no event later than 24 hours after there is reason to suspect abuse or neglect. The DHCFP expects that all providers be in compliance with the intent of all applicable laws.

The Aging and Disability Services Division (ADSD) accepts reports of suspected abuse, neglect or self-neglect, exploitation or isolation. Refer to NRS 200.5091 to 200.50995 regarding elder abuse or neglect.

6. SERIOUS OCCURRENCE REPORTS (SORS)

Providers must report any recipient incidents, or issues regarding the provider/employee's ability to deliver services. The 1915(i) Health Care Coordinator must be notified of serious occurrences within 24 hours of discovery. Providers must complete the web-based Nevada DHCFP SOR Form; this form is available at www.medicaid.nv.gov under Provider Forms. A completed SOR must be made by a provider within five business days and maintained in the provider's recipient record.

Serious occurrences involving either the provider, employee or recipient may include, but are not limited to the following:

a. Suspected physical or verbal abuse;

b. Unplanned hospitalization;

c. Neglect, exploitation or isolation of the recipient;

d. Theft;

e. Sexual harassment or sexual abuse;

f. Injuries requiring medical intervention;

g. An unsafe working environment;

h. Any event which is reported to Adult Protective Services or law enforcement agencies;

i. Death of the recipient during the rendering of 1915(i) services;

j. Loss of contact with the recipient for three consecutive scheduled days; or

k. Medication errors resulting in injury, hospitalization, medical treatment or death.

7. SERVICE PLAN

A service plan must be completed within 30 days of the recipient beginning services.

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.

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.

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.

8. TRAINING REQUIREMENTS

All employees must participate in a program of general orientation and must receive training on a regular basis, but not less than 12 hours per year.

General orientation training includes, but is not limited to:

a. policies, procedures and expectations of the provider, including recipient and provider rights and responsibilities;

b. record keeping and reporting including daily records and attendance records;

c. interpersonal and communication skills and appropriate attitudes for working effectively with recipients including:

1. understanding care goals,

2. respecting recipient rights and needs.

d. respect for age, cultural and ethnic differences;

e. recognizing family relationships;

f. confidentiality;

g. respecting personal property;

h. ethics in dealing with the recipient, family and other providers;

i. handling conflict and complaints; and

j. other topics as relevant.

NOTE: At least one employee trained to administer first aid and cardiopulmonary resuscitation (CPR) must be on the premises at all times.

1803.2 RECIPIENT RESPONSIBILITIES

Individuals receiving 1915(i) services are entitled to their privacy, to be treated with respect and be free from coercion and restraint.

The recipient or the recipient's designated representative will:

a. Notify the provider(s) and Health Care Coordinator of a change in Medicaid eligibility.

b. Notify the provider(s) and Health Care Coordinator of changes in medical status, service needs or changes of status of designated representative.

c. 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.

d. Notify the Health Care Coordinator if services are no longer requested or required.

e. Notify the provider(s) and the Health Care Coordinator of unusual occurrences, complaints regarding delivery of services or specific staff.

f. Not request a provider(s) to perform services not authorized in the plan of care.

g. Contact the Health Care Coordinator to request a change of provider.

1803.3 ADULT DAY HEALTH CARE (ADHC) SERVICES

Adult Day Health Care services provide assistance with the ADL, medical equipment and medication administration. Services include health and social services needed to ensure the optimal functioning of the participant. Services are generally furnished in four or more hours per day on a regularly scheduled basis, for one or more days per week. The schedule may be modified as specified in the plan of care.

1803.3A COVERAGE AND LIMITATIONS

Services provided by the appropriate professional staff include the following:

1. nursing services to include assessment, care planning, treatment and medication administration, evaluation and supervision of direct care staff;

2. nutritional assessment and planning;

3. care coordination to assist the recipient and family to access services needed by the recipient to maintain or improve their level of functioning or to minimize a decline in the level of functioning due to the progression of a disease or other condition that may not be remedied;

4. recipient training in ADL;

5. medical supervision and assistance to assure the recipient's well-being and that care is appropriate to meet the recipient's needs;

6. social and recreational activities to enhance the recipient's functioning and/or to maintain or improve the recipient's quality of life; and

7. meals provided as a part of these services shall not constitute a "full regimen" which is three meals per day.

NOTE: 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 for ADHC services.

1803.3B PROVIDER RESPONSIBILITIES

In addition to the Provider Responsibilities listed in Section 1803.1B, providers must adhere to the following requirements specific to rendering ADHC services:

1. PROVIDER QUALIFICATIONS

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.

2. STAFFING REQUIREMENTS

In addition to the requirements of NAC 449, each ADHC center must employ persons with the necessary education, skills and training to provide the Medicaid required services. Medical services must be provided by Nevada licensed/certified personnel and staff files maintained as required by the licensing entity.

a. REGISTERED NURSE (RN)

The center must employ a full time RN to oversee and provide medical services, particularly for physician ordered services. The RN must have at least one year of experience with the senior population, individuals with disabilities or individuals with a history of aggressive behavior. Within the first 30 days of admission, the RN must develop a Service Plan to indicate the management of each recipient's care and treatment. An RN or Licensed Practical Nurse (LPN) under the supervision of an RN, will administer medications provided to the recipient while in the center's care. An RN, or LPN under the supervision of an RN, must be physically on the premises during the hours in which a Medicaid recipient is in attendance at the center.

b. PROGRAM DIRECTOR

The center must employ a full time Program Director who has a minimum of two or more years of education and/or experience with the senior population, individuals with disabilities or individuals with a history of aggressive behavior.

The duties of the Program Director will include at a minimum the development of plans and policies for the center's operation, recruitment, employment and training of qualified staff, supervision and appropriate disciplinary action of staff, maintenance of employee and recipient information and records, maintenance of the center's physical plant, housekeeping and nutritional services and the development and implementation of an evaluation plan of recipient services and outcomes.

c. DIRECT CARE STAFF

The center must have direct care staff who observes the recipient's functioning and provide assistance to the recipient in the skills of daily living. Direct care staff must have education, experience and necessary qualifications to work with the senior population, individuals with disabilities or individuals with a history of aggressive behavior.

The center must also provide for janitorial, housekeeping and activity staff or other staff as necessary to provide the required services and ensure each recipient's needs are met.

d. ATTENDANCE RECORD AND NURSING NOTES

The center must have documentation of daily attendance and notes that indicate the health component of this service, which is maintained in the recipient's file. 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. The RN on duty or an LPN under the supervision of an RN, during the provision of services is responsible for documenting the recipient's care.

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.

1803.4 DAY HABILITATION

Day Habilitation services are regularly scheduled activities 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.

Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independent and personal choice. Services are identified in the recipient's POC according to recipient's need and individual choices. Meals provided as part of these services shall not constitute a "full nutritional regimen" (three meals per day).

Day Habilitation services focus on enabling the participant to attain or maintain his or her maximum potential and shall be coordinated with any needed therapies in the recipient's POC such as physical, occupational or speech therapy.

1803.4A COVERAGE AND LIMITATIONS

Day Habilitation services are targeted to individuals who have a TBI or ABI.

1803.4B PROVIDER RESPONSIBILITIES

In addition to the Provider Responsibilities listed in Section 1803.1B, providers must adhere to the following requirements specific to rendering Day Habilitation services.

1. PROVIDER QUALIFICATIONS

Each provider of Day Habilitation services must obtain and maintain certification as required in the 1915(i) State Plan.

2. ATTENDANCE RECORDS AND DAILY LOGS

The provider must have documentation of daily attendance and notes that indicate the health component of this service which is maintained in the recipient's file. 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. 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.

1803.5 RESIDENTIAL HABILITATION

Residential Habilitation means individually tailored supports that assist with the acquisition, retention or improvement in skills related to living in the community. These services include adaptive skill development, assistance with ADL, community inclusion, adult educational supports, social and leisure skill development that assist the recipient to reside in the most integrated setting appropriate to his/her needs. Residential habilitation also includes personal care, protective oversight and supervision.

1803.5A COVERAGE AND LIMITATIONS

Residential Habilitation services are targeted to individuals who have a TBI or ABI.

Additionally, payment for room and board is prohibited.

1803.5B PROVIDER RESPONSIBILITIES

In addition to the Provider Responsibilities listed in Section 1803.1B, providers must adhere to the following requirements specific to rendering Residential Habilitation services.

1. PROVIDER QUALIFICATIONS

Each provider of Residential Habilitation services must obtain and maintain certification as required in the 1915(i) State Plan

2. ATTENDANCE RECORDS AND DAILY LOGS

The provider must have documentation of daily attendance and notes that indicate the health component of this service which is maintained in the recipient's file. 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. 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.

1803.6 INTAKE AND ONGOING PROCEDURES

The following procedures describe how a person can obtain 1915(i) services and the process required to maintain services.

A. INTAKE PROCEDURES

1. A referral or inquiry for 1915(i) services may be initiated by phone, mail, fax, in person or by another party on behalf of the potential applicant.

2. 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 (CSHA) 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.

   a. If an applicant or representative fails to respond to the contact, a notification letter will be sent to the address on the referral form requesting contact within 10 business days, otherwise the referral will be closed.

3. If during the face-to-face assessment, the Health Care Coordinator determines the applicant does not appear to meet the needs-based criteria, a Notice of Decision will be mailed to the address on file and the applicant will be referred to other agencies for needed services or assistance not included under the 1915(i) program.

   The following reasons will serve as a basis for denial:

   a. The applicant is under the age of 18 years.

   b. The applicant does not meet the needs-based criteria.

   c. The applicant has withdrawn his or her request for 1915(i) services.

   d. The applicant's support system is not adequate to provide a safe environment during the time when services are not being provided.

   e. The DHCFP Health Care Coordinator has lost contact with the applicant.

   f. The applicant has moved out of state.

   g. Another agency or program will provide the services.

h. The applicant is in an institution (hospital, nursing facility, correctional or ICF) and discharge within 30 days is not anticipated.

i. The applicant has chosen a provider that is not an enrolled or qualified Medicaid provider.

j. There are no enrolled Medicaid providers in the applicant's area.

B. PERSON-CENTERED PLAN OF CARE

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. The 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.

POC DEVELOPMENT PROCESS:

1. The initial POC is developed based on information obtained during the initial assessment.

2. 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 documents this information in the CSHA narrative.

3. The POC reflects the recipient's service needs and includes both 1915(i) and non-1915(i) services in place at the time of POC completion, along with informal supports that are necessary to address those needs. The Health Care Coordinator is responsible for identifying services needed.

4. The POC development process considers risk factors, equipment needs, behavioral status, current support system and unmet service needs (this list is not all inclusive). 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.

5. 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.

6. The POC identifies the services required, including type, scope, amount, duration and frequency of services. The service providers are contacted by the Health Care Coordinator to establish availability and are given a copy of the recipient's POC prior to the initiation of services.

7. A recipient will receive a copy of the initial POC which must be signed within 60 calendar days of the date of the 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 document the recipient's verbal approval in the CSHA narrative and obtain the signature and date on the finalized POC.

8. 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.

9. The DHCFP Health Care Coordinators are responsible for prior authorizing 1915(i) services.

C. ONGOING PROCEDURES

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.

2. 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.

3. During the provision of services, if a recipient chooses to transfer to a different service provider, the recipient or representative must contact a DHCFP Health Care Coordinator to initiate the transfer process including the prior authorization for the new provider.

1803.7 TERMINATION OF 1915(i) SERVICES

Once a recipient is eligible for 1915(i) services, there may be circumstances which result in a recipient becoming ineligible for services. The following reasons serve as a basis for terminating a recipient from the 1915(i) HCBS State Plan Option:

A. The recipient is no longer eligible for Medicaid.

B. The recipient no longer meets the 1915(i) needs-based criteria.

C. The recipient/designated representative has requested termination of services.

D. The recipient has failed to cooperate with the DHCFP service providers in establishing and/or implementing the POC, implementing services or verifying eligibility for services. (The recipient/designated representative signature is necessary on all required paperwork).

E. The recipient's support system is not adequate to provide a safe environment during the time when 1915(i) services are not being provided.

F. The recipient fails to show a continued need for the minimum number of authorized hours for 1915(i) services.

G. The recipient has moved out of state.

H. The recipient chooses to transfer to a provider that is not an enrolled or qualified Medicaid provider.

I. The recipient has signed fraudulent documentation on one or more of the providers.

J. Another agency or program will provide the services.

K. The applicant is in an institution (e.g. hospital, nursing facility, correctional, ICF) and discharge within 30 days is not anticipated.

L. The DHCFP Health Care Coordinator has lost contact with the recipient.

1804 RATES AND REIMBURSMENT

Refer to the provider billing guide for instructions and the reimbursement code table for specific billing codes.

1805 QUALITY ASSURANCE

The DHCFP will conduct an annual review consisting of the quality measures required in the Quality Improvement Strategy outlined in the 1915(i) HCBS State Plan.

1806 TRANSPORTATION

Refer to MSM Chapter 1900 – Transportation Services, for requirements related to Emergency and Non-Emergency Transportation to Medicaid covered services.

1807 HEARINGS

Refer to MSM Chapter 3100, for the Medicaid Hearing process.