Medicaid Services Manual
Transmittal Letter

February 25, 2025

To: Custodians of Medicaid Services Manual

From: Casey Angres *Casey Angres* Casey Angres (Mar 3, 2025 15:09 PST)
Chief of Division Compliance

Subject: Medicaid Services Manual Changes
Chapter 1800 – 1915(i) State Plan Option - Adult Day Health Care and Habilitation

Background And Explanation

Revisions to Medicaid Services Manual (MSM) Chapter 1800 – 1915(i) State Plan Option - Adult Day Health Care and Habilitation are being proposed to align with the State Plan Amendment (SPA) renewal to be effective March 1, 2025. Major changes include expanding the needs-based eligibility criteria, additional requirements for serious occurrence reporting, provider staffing and training requirements for Day Habilitation and Residential Habilitation, additional denial reasons, and updates to the program procedures.

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

Entities Financially Affected: The proposed changes affect all Medicaid-enrolled providers delivering Adult Day Health Care provider type (PT 39) and Day and Residential 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, 2025.

Material Transmitted	Material Superseded
MTL 03/25 Chapter 1800 – 1915(i) HCBS State Plan Option Adult Day Health Care And Habilitation Services	MTL 02/23 and 27/23 Chapter 1800 – 1915(i) HCBS State Plan Option Adult Day Health Care And Habilitation Services

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1803.1	**NEEDS-BASED ELIGIBILITY CRITERIA**	Clarified the type of assistance needed as “hands-on” to complete the Activities of Daily Living (ADLs) and risk factor three regarding staff providing the services.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Added a fourth risk factor regarding a person with a brain injury being at risk of their medical condition worsening if not supervised by a trained direct care staff.
1803.1(B)(6)	**PROVIDER RESPONSIBILITIES**	Added language for verbal, sexual, psychological, and emotional abuse to align with Centers for Medicare and Medicaid Services (CMS) verbiage. Added language of financial to clarify exploitation. Deleted subparagraph (e). because it is captured in subgraph a revision. Clarified language regarding issues related to Law Enforcement agencies and medication errors. Added misuse or unauthorized use of restricted interventions or seclusion as a requirement for serious occurrence reporting.
1803.4B(1)(a-b)	**PROVIDER QUAIFICATIONS**	Added language regarding licensure for Day Habilitation facilities and appropriate procedure for notification of closure, suspension, or adverse action.
1803.4B(2)(a-b)	**STAFFING AND TRAINING REQUIREMENTS**	Added language regarding the specific certification and training time frames required for all staff who provide direct care for recipients diagnosed with Traumatic Brain Injury (TBI) and Acquired Brain Injury (ABI).
1803.5B(1)(a-b)	**PROVIDER QUALIFICATIONS**	Added language regarding licensure for Residential Habilitation facilities, and appropriate procedure for notification of closure, suspension, or adverse action.
1803.5B(2)(a-b)	**STAFFING AND TRAINING REQUIREMENTS**	Added language regarding the specific certification and training time frames required for all staff who provide direct care for recipients diagnosed with TBI and ABI.
1803.6A(1)(e)	**PROGRAM PROCEDURES**	Added that new referrals will have a 14-day period from the date of assessment to select a chosen provider and follow-up by Health Care Coordinator (HCC).
1803.6B(3)	**PROGRAM PROCEDURES**	Clarified that the transfer form should be submitted to the 1915(i) inbox and procedure for the new provider Plan of Care (POC).

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1803.6D(1)(l-o)	**NOTICE OF DECISION (NOD) FOR 1915(i) SERVICES**	Added language regarding no enrolled Medicaid providers in the applicant's area, no provider willing to accept a new referral, applicant fails to select an enrolled Medicaid provider, and death of the applicant.

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 a 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
    - 42 CFR 441.301(c)(1) through (c)(5) – HCBS Settings Final Regulation and Settings Requirements.
- 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) 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 hands-on 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; or

2. At risk of a chronic medical condition being exacerbated if not supervised by a registered nurse (RN); or

3. At risk of aggressive behavior if not supervised by an RN or if medication is not administered by appropriate staff; or

4. At risk of their medical condition worsening, a person with a brain injury requires supervision by a trained direct care staff.

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) as diagnosed by a physician.

c. Residential Habilitation-targeted to individuals with TBI or ABI as diagnosed by a physician.

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 (NF), correctional 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.

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 Medicaid Services Manual (MSM) Chapter 100, Medicaid Program. 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 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 DHCFP.

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

4. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (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. 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.

6. SERIOUS OCCURRENCE REPORTS (SORS)

Providers must report any serious occurrences within 24 hours of the initial discovery. Providers must complete the web-based Nevada DHCFP SOR Form; available at https://medicaid.nv.gov/ under Provider Forms. After the initial notification, any changes to the information initially reported about the serious occurrence(s) must be updated 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 verbal, physical, sexual, psychological, or emotional abuse;

b. Unplanned hospitalization;

c. Neglect, financial exploitation, isolation, abandonment, or unexpected death of the recipient;

d. Theft;

e. Injuries requiring medical intervention;

f. An unsafe working environment;

g. Any event which is reported to Adult Protective Services (ages 18 years old and above) or involves law enforcement agencies;

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

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

j. Medication errors resulting in a consultation with a poison control center, an urgent care visit, an emergency department visit, hospitalization, or death;

k. Misuse or unauthorized use of restrictive interventions or seclusion; and

l. Elopement of a resident residing in a residential facility for the care of adults.

7. 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.

8. HCBS FINAL RULE REQUIREMENTS AND TRAINING

a. Ensure that HCBS Settings requirements and expectations are followed. The HCBS Settings Regulation supports enhanced quality in HCBS programs, adds protections for individuals receiving services and supports through Medicaid's HCBS programs have full access to the benefits of community living and can receive services in the most integrated setting.

b. Paid and unpaid staff must annually receive one hour of training related to the rights of the individual receiving services and individual experience outlined in the HCBS Final Regulation.

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 HCC of a change in Medicaid eligibility.

B. Notify the provider(s) and HCC of changes in medical status, service needs, or changes of status of designated representative.

C. Cooperate with the HCC by assisting with the assessment process.

D. 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.

E. Notify the HCC if services are no longer requested or required.

F. Notify the provider(s) and the HCC of serious occurrences, complaints regarding delivery of services or specific staff.

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

H. Review and sign the 1915(i) Transfer form when requesting a change in 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. ADHC services are activities on a regularly scheduled basis, for a minimum of one day per week.

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. assist with ADL(s) as identified in the 1915(i) HCBS Plan of Care (POC);

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

a. 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.

b. The provider must notify DHCFP via email to 1915i@dhcfp.nv.gov within 24 hours of the event of closure, suspension or adverse action taken by Health Care Quality and Compliance (HCQC).

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. 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. 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.

3. DOCUMENTATION

a. ATTENDANCE LOG

The facility must have documentation of daily attendance recorded on a log which includes: recipient's full name, date, time-in, time-out, and recipient's initials or signature.

b. NURSING LOG

The delivery of specific services required by the 1915(i) POC, must be documented in the nursing log. The RN on duty or an LPN under the supervision of an RN, during the provision of services is responsible for documenting in the recipient's file.

1. Nursing logs shall include the following information, but not limited to: recipient's full name, health component of the services, date of service provided, and initials of the direct care staff.

2. An appropriate provider staff member must sign and date the nursing log at minimum on a monthly basis indicating services were provided.

c. SIGNATURES

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.

2. The recipient must sign or initial the attendance log.

   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 Section 1803.6C(7)(c).

3. The facility may create a signature page which a designated representative should sign on behalf of the recipient for the attendance log and any other signature requirements.

1803.4 DAY HABILITATION

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.

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 1915(i) 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

a. Each provider of Day Habilitation services must obtain and maintain certification as required in the 1915(i) State Plan. Providers must adhere to all requirements of NAC 449 as applicable to licensure.

b. The provider must notify DHCFP via e-mail to 1915i@dhcfp.nv.gov within 24 hours of the event of closure, suspension, or adverse action taken by HCQC.

2. STAFFING AND TRAINING REQUIREMENTS

a. Within six months of the date of hire, any direct care staff must have completed the Brain Injury Association of America (BIAA) Brain Injury Fundamentals Certification and must maintain a current certification. Direct care staff include, but are not limited to, licensed professional staff and non-licensed staff who provide care for recipients diagnosed with TBI or ABI.

b. A facility must also have a designated person with a Certified Brain Injury Specialist (CBIS) or Certified Brain Injury Specialist Trainer (CBIST) Certification through BIAA to support the direct care staff with necessary education, skills, and training.

3. DOCUMENTATION

a. ATTENDANCE LOG

The facility must have documentation of daily attendance logs which includes: recipient's full name, date, time-in, time-out, and recipient's initials or signature.

b. SERVICE LOG

The delivery of specific services required by the 1915(i) POC must be documented in the daily service log and maintained in the recipient's file.

1. The service log shall include the following information, but not limited to: recipient's full name, health component of the services, date of service provided, and initials of the direct care staff.

2. An appropriate provider staff member must sign and date the service log at minimum on a monthly basis indicating services were provided.

This documentation is verification of service provision and may be used to review claims paid.

c. SIGNATURES

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.

2. The recipient must sign or initial the attendance log.

3. 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 Section 1803.6C(7)(c).

4. The facility may create a signature page which a designated representative should sign on behalf of the recipient signature for the attendance log 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 their needs. Residential Habilitation also includes personal care, protective oversight, and supervision 24 hours a day.

Services are identified in the recipient's 1915(i) POC according to recipient's need and individual choices.

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

a. Each provider of Residential Habilitation services must obtain and maintain certification as required in the 1915(i) State Plan. Providers must adhere to all requirements of NAC 449 as applicable to licensure.

b. The provider must notify DHCFP via e-mail to 1915i@dhcfp.nv.gov within 24 hours of the event of closure, suspension, or adverse action taken by HCQC.

2. STAFFING AND TRAINING REQUIREMENTS

a. Within six months of the date of hire, any direct care staff must have completed the BIAA Brain Injury Fundamentals Certification and must maintain a current certification. Direct care staff include, but are not limited to, licensed professional staff and non-licensed staff who provide care for recipients diagnosed with TBI or ABI.

b. A facility must also have a designated person with a CBIS or CBIST Certification through BIAA to support the direct care staff with necessary education, skills, and training.

3. DOCUMENTATION

a. SERVICE LOG

The delivery of specific services required by the 1915(i) POC must be documented in the daily service log and maintained in the recipient's file.

1. The facility must have documentation of daily service recorded on a log which includes: recipient's full name and date, health component of this service, date of service provided and initials of the direct care staff.

2. An appropriate provider staff member must sign and date the service log at minimum on a monthly basis indicating services were provided.

This documentation is verification of service provision and may be used to review claims paid.

b. SIGNATURES

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.

2. The recipient must sign the service log at minimum on a monthly basis. 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 as referenced in Section 1803.6C(7)(c).

3. The facility may create a signature page which a designated representative should sign on behalf of the recipient for the service log and any other signature requirements.

c. NOTIFICATIONS

If the facility issues an eviction notice or discharges a recipient from the facility, the facility should notify DHCFP via email to 1915i@dhcfp.nv.gov within 48 hours. Facility must adhere to all requirements of NRS 449A as applicable regarding recipient's rights.

1. EVICTION

If a facility chooses to evict a resident from a Residential Habitation facility, the facility must provide the resident or their designated representative with a 30-day written notice indicating the reason(s) for the eviction.

2. DISCHARGE

A recipient voluntary or involuntarily discharges from the facility under any certain circumstances.

1803.6 PROGRAM PROCEDURES

The following procedures describe how a person can obtain DHCFP 1915(i) HCBS services and the process required to maintain services utilizing a needs-based criteria to assess and re-assess whether an individual is eligible.

A. ASSESSMENT

1. NEW REFERRAL

a. A family member or applicant who is interested in receiving 1915(i) services may initiate a new referral by email, phone, mail, fax, in person, or by another party on behalf of the potential applicant.

b. A referral form can be found on the DHCFP website.

c. All required fields must be completed, and requested documentation included, in order for the referral to be accepted.

d. 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 (CSHA) tool. DHCFP HCC will contact the applicant/representative within seven working days of the referral date to schedule a time to conduct an assessment.

e. If an applicant is authorized for the 1915(i) program but cannot start services because they need more time to select a provider or are waiting for a bed opening in a residential setting, the applicant has 14 days from the date of the assessment to still be considered a New Referral. Once the applicant can begin services, DHCFP HCC will utilize the original assessment to develop the POC unless there has been a change in condition. If an applicant has a change in condition from the original assessment date, then DHCFP HCC would conduct a new assessment to determine any additional needs.

2. RE-ASSESSMENT

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.

B. TRANSFER

Once a recipient is approved for services, their authorization is for a year period. During that year, if a recipient chooses to transfer to a different service provider, the recipient or representative must contact DHCFP to initiate the transfer process by using the 1915(i) Transfer form, which can be found on the DHCFP website.

1. The recipient or representative and the new provider must complete and sign the Transfer form.

2. DHCFP will review the transfer request and may conduct a visit to verify the recipient's needs if there is a change of condition since the last assessment or other circumstances occur.

3. Once DHCFP approves the transfer request, DHCFP will authorize the new provider for the remainder of the year period and send an updated POC to the newly chosen provider for signature.

4. A recipient may not begin services at the newly chosen provider until the transfer request has been approved and authorized.

C. PERSON-CENTERED POC

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.

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. The POC development process includes the following:

1. The POC is developed based on information obtained during the 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 HCC 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. HCC 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 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 assessment. The recipient must sign the Statement of Choice (SOC) 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.

7. A recipient will receive a copy of the POC which must be signed within 60 calendar days of the date of the 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 CSHA 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.

8. 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 for the case file.

9. DHCFP HCCs are responsible for prior authorizing 1915(i) services.

D. NOTICE OF DECISION (NOD) FOR 1915(i) SERVICES

When DHCFP takes an adverse action such as denial, termination, or reduction of services, a NOD will be sent to the address on file with the Division of Welfare and Supportive Services (DWSS) or other address as instructed. The NOD will identify the service type, the reason, and the effective date.

1. DENIAL NOD FOR SERVICES

   If during the assessment, the HCC determines the applicant does not appear to meet the eligibility criteria, a NOD 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 not eligible for Medicaid.

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

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

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

e. The applicant has failed to cooperate with DHCFP HCC in completing the application process including the assessment.

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

g. DHCFP HCC has lost contact with the applicant.

h. The applicant has moved out of state.

i. Another agency or program will provide the services.

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

k. The applicant has chosen a provider that is not an enrolled Medicaid provider.

l. There are no enrolled Medicaid providers in the applicant's area or any willing providers to accept the new referral.

m. The applicant failed to choose/select a 1915(i) enrolled Medicaid Provider.

n. The applicant has a higher level of needs that cannot be met by the 1915(i) services.

o. Death of applicant.

2. TERMINATION NOD FOR 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 DHCFP service providers in

establishing and/or implementing the provider's POC, implementing services or verifying eligibility for services. (The recipient/designated representative signature is necessary on all required paperwork).

e. The recipient has failed to cooperate with DHCFP HCC in completing the re-assessment process.

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

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

h. The recipient has moved out of state.

i. The recipient chooses a provider that is not an enrolled Medicaid provider.

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

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

l. Another agency or program will provide the services.

m. The recipient is in an institution (e.g. hospital, NF, correctional, ICF) and discharge within 30 days is not anticipated.

n. DHCFP HCC has lost contact with the recipient.

o. The recipient has a higher level of needs that cannot be met by the 1915(i) services.

p. Death of recipient.

3. REDUCTION OF SERVICES

The following reasons will serve as a basis for reduction of services:

a. The recipient no longer requires the number of service hours which was previously authorized.

b. The recipient no longer requires the service previously authorized.

c. The recipient's support system is capable of providing the service.

d. The recipient has requested the reduction of services.

e. The recipient's functional ability has improved.

f. Another service will be substituted for the existing service.

1804 RATES AND REIMBURSMENT

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

1805 QUALITY ASSURANCE

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.