Medicaid Services Manual
Transmittal Letter

December 30, 2024

To: Custodians of Medicaid Services Manual

From: Casey Angres *Casey Angres* Casey Angres (Feb 11, 2025 16:16 PST)

Chief of Division Compliance

Subject: Medicaid Services Manual Changes
Chapter 4200 – Medicaid Health Home for Beneficiaries with Fetal Alcohol Spectrum Disorder (FASD)

Background And Explanation

A new Medicaid Services Manual (MSM) Chapter 4200 - Medicaid Health Home for Beneficiaries with FASD is being proposed to provide a variety of services to individuals with FASD via the Medicaid health home model. The proposed FASD health home will provide comprehensive care management and coordination services to Medicaid beneficiaries with FASD. For enrolled beneficiaries, the FASD health home will function as the central point of contact for directing patient-centered care across the broader health care system. Beneficiaries will work with an interdisciplinary team of providers to develop a person-centered health action plan to best manage their care. The model will also elevate the role and importance of Peer Specialists and Community Health Workers (CHW) to foster direct empathy and raise overall health and wellness. In doing so, this will attend to a beneficiary's complete physical, behavioral, and health-related social needs.

Participation is voluntary and enrolled beneficiaries may opt-out at any time. Nevada has four overarching goals for the FASD health home: Improve care management of beneficiaries with FASD; Increase access to and utilization of evidence-based services for FASD, including but not limited to, applied behavioral analysis (ABA); Decrease the onset of behavioral issues that can manifest because of FASD; and Provide services aimed at allowing individuals with FASD to remain in home and community-based settings.

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: These proposed changes affect all Medicaid-enrolled providers delivering services to Medicaid beneficiaries who have FASD. Those provider types (PT) include but are not limited to: ABA (PT 85), Psychologist (PT 26), Physician, M.D., Osteopath, D.O. (PT 20), Advanced Practice Registered Nurse (APRN) (PT 24).

Financial Impact on Local Government for state fiscal years (SFY) 2025 and 2026:

SFY 2025: $18,362
SFY 2026: $90,371

These changes are effective April 1, 2025.

Material Transmitted	Material Superseded
MTL 29/24 Chapter 4200 – Medicaid Health Home for Beneficiaries with FASD	MTL NEW Chapter 4200 – Medicaid Health Home for Beneficiaries with FASD

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
4200	**Introduction**	Added “Introduction” Section.
4201	**Authority**	Added “Authority” Section.
4202	**Policy**	Added “Policy” Section.
4202.1	**Eligibility Criteria**	Added “Eligibility Criteria” Section.
4202.2	**Geographic Area**	Added “Geographic Area” Section.
4202.3	**Program Enrollment**	Added “Program Enrollment” Section.
4202.4	**Coverage and Limitations**	Added “Coverage and Limitations” Section.
4202.4A	**Authorization Process**	Added “Authorization Process” Section.
4202.4B	**Covered Services**	Added “Covered Services” Section.
4202.4C	**Non-Covered Services**	Added “Non-Covered Services” Section.
4202.5	**Provider Qualifications**	Added “Provider Qualifications” Section.
4202.6	**Provider Responsibility**	Added “Provider Responsibility” Section.
4203	**Hearings**	Added “Hearings” Section.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
TABLE OF CONTENTS

MEDICAID HEALTH HOME FOR BENEFICIARIES WITH FETAL ALCOHOL SPECTRUM DISORDER (FASD)

4200 INTRODUCTION

Fetal alcohol spectrum disorders (FASD) are a group of conditions that can occur in a person who was exposed to alcohol prenatally. FASD can range from mild to severe and may have lifelong effects, including problems with behavior and learning as well as physical problems. Physical problems may include lower-than-average height and/or weight; poor coordination; problems with the heart, kidneys, or bones; vision or hearing problems; and abnormal facial features. In terms of learning and behavioral problems, FASD symptoms are often misdiagnosed as Attention Deficit/Hyperactivity Disorder (ADHD), Attention Deficit Disorder (ADD), Oppositional Defiant Disorder (ODD), adolescent depression, or bipolar disorder. This policy provides comprehensive care management and coordination services for Medicaid beneficiaries with FASD.

Section 1945 of the Social Security Act (SSA) created an optional Medicaid State Plan benefit for states to establish health homes to coordinate care for Medicaid beneficiaries with complex needs. Medicaid health home programs provide person-centered, team-based care coordination to more than one million Medicaid beneficiaries in the United States with chronic conditions. Health homes are designed for populations with two or more chronic conditions, one chronic condition and the risk of developing another, or one serious and persistent mental health condition whose health and safety needs are not well managed in community settings.

All providers participating in the Medicaid program must furnish services in accordance with the rules and regulations of the Medicaid program. See Medicaid Services Manual (MSM) Chapter 100, Medicaid Program.

4201 AUTHORITY

Section 2703 of the Affordable Care Act added Section 1945 to the SSA, allowing states the option to provide coordinated care through a Health Home for individuals with chronic conditions.

Statutes and Regulations:

- SSA
  - Title XIX
  - Title XXI
  - Section 1945
- Nevada Revised Statutes (NRS):
  - Chapter 422, including 422.3966 as added by Assembly Bill (AB) 137 of 2023
  - Chapter 432B

4202 POLICY

4202.1 ELIGIBILITY CRITERIA

Medicaid and Child Health Insurance Program (CHIP) beneficiaries with FASD and having/being at risk of another chronic condition are eligible for the FASD health home.

A. For the purposes of FASD, this means having confirmed or probable prenatal exposure to alcohol through clinical or self-attestation and/or having a diagnosis associated with one of the following International Classification of Diseases (ICD)-10 codes:

1. P04.3: Newborn affected by maternal use of alcohol (Excludes FASD)
2. Q86.0: Fetal alcohol syndrome (dysmorphic)

B. Beneficiaries meeting the criteria above must have or be at risk of other chronic conditions, including but not limited to:

1. Abnormal facial features
2. Abnormal findings on functional studies of the peripheral nervous system and special senses
3. ADHD
4. Autism Spectrum Disorder (ASD)
5. Cognitive delay
6. Conduct disorder
7. Chronic serous otitis media
8. Expressive language disorder
9. Externalizing disorders
10. Low body weight
11. Special learning disorders
12. Pervasive and developmental disorders
13. Intellectual disabilities
14. Neurobehavioral disorders associated with prenatal exposure to alcohol

15. Mood disorders (e.g., depression, anxiety, post-traumatic stress disorder (PTSD))
16. ODD
17. Psychotic disorders
18. Receptive language disorder
19. Speech and language delays
20. Poor coordination
21. Vision or hearing problems

4202.2 GEOGRAPHIC AREA

The FASD Health Home will be available statewide.

4202.3 PROGRAM ENROLLMENT

Potential FASD health home enrollees will be identified through one of two mechanisms: claims-based enrollment or provider-recommended enrollment.

A. Claims-Based Enrollment: The State will identify prospective FASD health home enrollees through Medicaid claims data, specifically beneficiaries with claims showing a P04.3 or Q86.0 ICD-10 code diagnosis. These beneficiaries will be automatically assigned to a Health Home Provider (HHP) based on geographic proximity. Once assigned, the HHP will conduct outreach to prospective FASD health home enrollees (and their families/caregivers) to verify eligibility and obtain beneficiary/caregiver/guardian consent to participate. The HHP will then submit eligibility verification, consent documentation, and other supporting materials to the State for review and formal enrollment into the FASD health home. Once enrolled, the State will activate the benefit plan in the Medicaid Management Information System (MMIS) for the beneficiary.

B. Provider-Recommended Enrollment: The HHP will conduct outreach to prospective FASD health home enrollees not automatically assigned through claims-based enrollment to determine eligibility and obtain beneficiary/caregiver/guardian consent to participate. If the beneficiary is interested in enrolling in the health home, the HHP will then submit eligibility verification, consent documentation, and other supporting materials to the State for review and formal enrollment into the FASD health home. Once enrolled, the State will activate the benefit plan in the MMIS for the enrolled beneficiary and include the beneficiary in the monthly enrollment reports provided to the Managed Care Organizations (MCO).

4202.4 COVERAGE AND LIMITATIONS

4202.4A AUTHORIZATION PROCESS

FASD health home services do not require prior authorization. Once an eligible beneficiary is enrolled, FASD HHPs must submit claims to Nevada Medicaid's fiscal agent.

4202.4B COVERED SERVICES

The goal of the FASD health home is to promote access to and coordination of care. Under the Medicaid State Plan option, states have flexibility to define the core health home services, but they must provide all six core services, linked as appropriate and feasible by health information technology. These services include:

1. Comprehensive care management: the initial and ongoing assessment and care management services aimed at the integration of primary, behavioral, and specialty health care and community support services, using a comprehensive person-centered care plan that addresses all clinical and non-clinical needs and promotes wellness and management of chronic conditions in pursuit of optimal health outcomes. This includes, but is not limited to:

    a. Outreach and engagement activities to gather information from the enrollee, the enrollee's support member(s), and other primary and specialty care providers;

    b. Assessment of each enrollee, including behavioral and physical health care needs;

    c. Development of a comprehensive person-centered care plan;

    d. Documentation of the assessment and care plan in the Electronic Health Record (EHR);

    e. Periodic reassessment of each beneficiary's treatment, outcomes, goals, self-management, health status, and service utilization in relation to the health home;

    f. Chronic care management (e.g., management of multiple chronic conditions); and

    g. Management of unmet health-related resource needs and high-risk social environments.

2. Care coordination: the facilitation of access to, and the monitoring of, services identified in a person-centered care plan to manage chronic conditions for optimal health outcomes and to promote wellness. Care coordination includes the facilitation of the interdisciplinary teams to perform a regular review of person-centered care plans and monitoring service delivery and progress toward goals. This is accomplished through face-to-face and collateral contacts with the health home enrollee, family, informal and formal caregivers,

and with primary and specialty care providers. It also includes facilitation and sharing of centralized information to coordinate integrated care by multiple providers through use of EHRs that can be shared among all providers. This includes, but is not limited to:

a. Ensuring the enrollee has an ongoing source of care;

b. Implementing the person-centered care plan;

c. Management of all integrated primary and specialty medical services, behavioral and physical health services, and developmental, social, educational, vocational, housing, and community services;

d. Continuous monitoring of progress towards goals identified in the person-centered care plan through face-to-face and collateral contacts with enrollee, enrollee's support member(s), and primary and specialty care providers;

e. Supporting the enrollee's adherence to prescribed treatment regimens (including medication-assisted treatment) and wellness activities, including medication adherence and monitoring;

f. Participating in the hospital discharge processes to support the enrollee's transition to a non-hospital setting and requiring discharge summaries;

g. Communicating, information sharing, and consulting with other providers and the enrollee and enrollee's authorized representative(s), and family, as appropriate;

h. Facilitating regularly scheduled interdisciplinary team meetings to review care plans and assess progress;

i. Providing assistance with making appointments, including coordinating transportation;

j. Tracking referrals;

k. Tracking enrollee test results; and

l. Connecting enrollees to resources (e.g., smoking cessation, substance use disorder (SUD) treatment, nutritional counseling, obesity reduction and prevention, disease-specific education, etc.).

3. Health promotion: the education and engagement of an individual in making decisions that promote an enrollee's maximum independent living skills and lifestyle choices that achieve the following goals: good health, pro-active management of chronic conditions, early identification of risk factors, and appropriate screening for emerging health problems. This includes, but is not limited to:

a. Promoting enrollees' and their families' education on their chronic condition (e.g., diabetes education, nutrition education);

b. Promoting health lifestyle interventions;

c. Encouraging routine preventative care such as immunizations and screenings;

d. Conducting medication reviews and regimen compliance;

e. Assessing the patient's and family's understanding of the health condition and motivation to engage in self-management;

f. Promoting wellness and prevention programs by assisting health home enrollees with resources that address exercise, nutrition, stress management, substance use reduction/cessation, smoking cessation, self-help recovery resources, and other wellness services based on enrollee needs and preferences; and

g. Using evidence-based practices to engage and help enrollees participate in and manage their care.

4. Comprehensive transitional care and follow-up: the facilitation of services for enrollees and family/caregivers when the individual is transitioning between levels of care (including, but not limited to hospital, nursing facility, rehabilitation facility, community-based group home, family or self-care) or when an individual is electing to transition to a new HHP. This involves developing relationships with hospitals and other institutions and community providers to ensure and foster efficient and effective care transitions. Each health home should establish a written protocol on the care transition process with hospitals (and other community-based facilities) to set up real-time sharing of information and care transition records for health home enrollees. This includes, but is not limited to:

a. Establishing relationships with hospitals, residential settings, rehabilitation settings, other treatment settings, and long-term services and supports providers to promote a smooth transition if the enrollee is moving between levels of care or back to the community.

b. This includes prompt notification and ongoing communication of enrollees' admission and/or discharge to and from an emergency room, inpatient residential, rehabilitative, or other treatment settings.

c. If applicable, this relationship should also include active participation in discharge planning with the hospital or other treatment settings to ensure consistency in meeting the goals of the enrollee's person-centered care plan.

d. Communicating and providing education to the enrollee, the enrollee's designated representative and/or family member, and the providers that are located at the

setting from which the person is transitioning, and at the setting to which the individual is transitioning.

e. Developing a systemic protocol to assure timely access to follow-up care post discharge that includes, at a minimum, all of the following:

1. Receipt of a summary of care record from the discharging entity;

2. Medication reconciliation;

3. Pharmacy coordination;

4. Reevaluation of the care plan to include and provide access to needed community support services; and

5. A plan to ensure timely scheduled appointments.

5. Individual and family supports: the coordination of information and services to support enrollees and enrollees' support members to maintain and promote the quality of life, with particular focus on community living options. This includes, but is not limited to:

a. Providing education and guidance in support of self-advocacy;

b. Providing caregiver counseling or training on skills needed to: provide specific treatment regimens to help the individual improve function, obtain information about the individual's disability or conditions, and navigation of the service system;

c. Identifying resources to assist enrollees and family support members in acquiring, retaining, and improving self-help, socialization, and adaptive skills; and

d. Providing information and assistance in accessing services such as self-help, peer support, and respite.

6. Referral to community and social services: the provision of information and assistance for the purpose of referring enrollees and enrollee support members to community-based resources, regardless of funding source, that can meet the needs identified on the enrollee's person-centered care plan. This includes, but is not limited to:

a. Providing referral and information assistance to individuals on obtaining community-based resources and social support services, including SUD supports, disability benefits (e.g., Supplemental Security Income (SSI)/Supplemental Security Disability Income (SSDI)), food and income supports, housing, transportation, employment services, education, child welfare services, domestic violence services, legal services, faith-based services, and other services that help individuals achieve their highest level of function and independence;

b. Identifying resources to reduce barriers to help individuals achieve their highest level of function and independence; and

c. Monitoring and follow up with referral sources, enrollee, and enrollee's support member, to ensure appointments and other activities, including employment and other social community integration activities, were established and enrollee was engaged in services.

4202.4C NON-COVERED SERVICES

1. Services outside of the six core health home services cited in Section 4202.4B.

2. Case management, care coordination, or other services covered by other Nevada Medicaid programs/benefits that may result in duplication with health home services.

4202.5 PROVIDER QUALIFICATIONS

DHCFP will designate select providers as FASD HHPs. To become a designated FASD HHP, the standards and care team requirements cited below must be met.

A. Required Standards:

1. Be enrolled as a Nevada Medicaid provider and be in compliance with all applicable program policies;

2. Meet and maintain all state requirements for participation, along with all standard provider policies for participation with Medicaid;

3. Adhere to all federal and state laws in regard to Health Home recognition/certification, including the capacity to perform all core services specified by the Centers for Medicare & Medicaid Services (CMS);

4. Submit an application to the State attesting to meeting HHP requirements;

5. Operate a multidisciplinary clinic for the assessment of individuals who may have FASD, with expertise in disciplines such as genetics/dysmorphology, developmental-behavioral pediatrics, and pediatric/clinical neuropsychology;

6. Submit health home eligibility information for prospective enrollees to the State for enrollment;

7. Ensure person-centered and integrated care planning that coordinates and integrates all clinical and non-clinical health care related needs and services;

8. Provide quality-driven, cost-effective, and evidence-based health home services in a culturally competent manner that addresses health disparities and improves health literacy;

9. Adhere to all provider requirements and all program requirements, and participate in initial Health Home program orientation and subsequent training(s);

10. Demonstrate the ability to perform each of the following functional requirements. This includes documentation of the processes and methods used to execute these functions;

11. Coordinate and provide the six core services cited in Section 2703 of the Affordable Care Act/Section 1945 of the SSA;

12. Coordinate and provide access to high-quality health care services;

13. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and SUDs;

14. Coordinate and provide access to physical, mental health, and SUD services.

15. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families;

16. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices as appropriate;

17. Establish a continuous quality improvement program and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level;

18. Demonstrate the ability to report required data for both state and federal monitoring of the program.

19. Communicate with Medicaid Health Plans to ensure the health plans are aware of which members are enrolled in a health home; and

20. Participate in a readiness assessment that includes a gap analysis and mitigation plan.

B. Care Team Requirements: FASD HHPs must include the following professionals meeting the specified criteria:

1. Health Home Director: a medical or health services manager with a bachelor's degree in business, health policy, health administration, public administration, or a closely related field and at least five years of experience in health administration, business administration, or public health management; or a master's degree in business, health policy, health administration, public administration, or a closely related field.

    a. Provides overarching leadership for health home services;

    b. Provides coordination of health home activities;

    c. Collects and reports on data that permits an evaluation of increased coordination of care and chronic disease management; and

    d. Monitors health home performance and leads quality improvement efforts.

2. Health Home Coordinator: an administrator with a bachelor's degree in business, health policy, health administration, public administration, or a closely related field and at least two years of experience in health or business administration.

    a. Supports the Health Home Director;

    b. Designs and develops prevention and wellness initiatives, and referral tracking;

    c. Executes enrollment using the State's application system/provider portal;

    d. Provides training and technical assistance; and

    e. Provides data management and reporting.

3. Care Manager: an individual who meets one of the following criteria: A bachelor's degree from an accredited college or university with major work in early childhood growth and development, early childhood special education, psychology, counseling, social work, or a closely related field, and one year of full-time professional experience in an early integrated preschool program, mental health facility, or a clinical setting providing developmental or special education or treatment-oriented services to preschool or school age children with physical or mental disabilities, or emotional or behavioral disorders; A master's degree from an accredited college or university in early childhood special education, childhood human growth and development, psychology, counseling, social work, or a closely related field; A doctorate degree and license in psychology; A registered Nurse (RN); or an Advanced Practice Registered Nurse (APRN) in mental health or a mental health professional who works under the direct supervision of a person listed above. These individuals should meet the requirements of a Qualified Mental

Health Professionals (QMHP) or Qualified Mental Health Associates (QMHA), or Qualified Intellectual Disabilities Professional (QIDP) as cited in MSM Chapter 400 and MSM Chapter 2100, respectively.

a. Coordinates all aspects of the individual's care;

b. Participates in initial care plan development, including specific goals for all enrollees;

c. Meets regularly with the care team to plan care and discuss cases, and exchange appropriate information with team members in an informal manner as part of the daily care of the enrollee;

d. Participates in the selection of strategies to implement evidence-based wellness and prevention initiatives;

e. Monitors and reports performance measures and outcomes; and

f. Facilitates the use of the EHR and other Health Information Technology (HIT) to link services, facilitate communication among team members and provide feedback.

4. Care Manager Extender: a certified Peer Supporter (per MSM Chapter 400) with applicable lived experience or community health worker certified by the Nevada Certification Board (per MSM Chapter 600).

a. Coordinates and provides access to individual and family supports, including referral to community social supports;

b. Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic;

c. Identifies community resources (e.g., social services, workshops, etc.) for patient to utilize to maximize wellness;

d. Conducts referral tracking;

e. Coordinates and provides access to chronic disease management, including self-management support;

f. Implements wellness and prevention initiatives;

g. Facilitates health education groups; and

h. Provides education on health conditions and strategies to implement care plan goals, including both clinical and non-clinical needs.

5. Specialized Health Home Consultant: a behavioral health specialist, Board-Certified Behavior Analyst, dietician/nutritionist, occupational therapist, physical therapist, recreational therapist, speech therapist, health education specialist, or early intervention specialist, allows the health home to have flexibility in offering additional consultation from a variety of healthcare professionals, including the following:

a. Behavioral Health Specialist: a licensed behavioral health professional operating within the scope of their practice under state law who has specific education, experience, training, credentials to oversee any array of behavioral health services (per MSM Chapter 400).

1. Participates in initial care plan development, including specific goals for all enrollees;

2. Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic;

3. Refers enrollees to other behavioral specialists as needed;

4. Screens/evaluates individuals for mental health and SUDs;

5. Refers enrollees to licensed mental health providers and/or SUD therapists, as necessary;

6. Provides brief intervention for individuals with behavioral health problems;

7. Supports other providers in identifying and behaviorally intervening with patients;

8. Focuses on managing a population of patients versus specialty care;

9. Works with patients to identify chronic behavior, discuss impact, and develop improvement strategies and specific goal-directed interventions;

10. Develops and maintains relationships with community-based mental health and substance use providers;

11. Identifies community resources (e.g., support groups, workshops, etc.) for patient to utilize to maximize wellness; and

12. Provides patient education.

b. Board-Certified Behavior Analyst: a master's level, independent practitioner certified by the Behavior Analyst Certification Board (per MSM Chapter 3700).

1. Provides behavior-analytic services to health home enrollees as needed;

2. Participates in initial care plan development, including specific goals for all enrollees;

3. Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic; and

4. Refers enrollees to other behavioral specialists as needed.

c. Dietician/Nutritionist: a Registered Dietician (as per NRS 640E).

1. Provides assessment of enrollees' overall nutritional status and individualized dietary assessment;

2. Plans and implements nutritional intervention and counseling using evidence-based nutrition practice guidelines to achieve nutritional goals and desired health outcomes;

3. Participates in initial care plan development, including specific goals for all enrollees; and

4. Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.

d. Occupational Therapist: an occupational therapist with a current registration issued by the American Occupational Therapy Association or another comparable body (as per NRS 640A).

1. Assesses the enrollee's rehabilitation potential and needs;

2. Provides skilled occupational therapy services;

3. Participates in initial care plan development, including specific goals for all enrollees; and

4. Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.

e. Physical Therapist: a physical therapist with a current registration to practice physical therapy issued by the Nevada State Board of Physical Therapy Examiners (as per NRS 640).

1. Develops a written individual program of treatment to prevent/alleviate movement dysfunction and related functional problems, including motor delays, disabilities and/or physical impairments affecting areas such as tone, coordination, movement, strength, and balance;

2. Participates in initial care plan development, including specific goals for all enrollees; and

3. Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.

f. Recreation Therapist: a professional recreation specialist with a bachelor's degree in recreation or in a specialty area such as art, dance, music, or physical education.

1. Provides recreation therapy to enrollees as needed;

2. Participates in initial care plan development, including specific goals for all enrollees; and

3. Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.

g. Speech Pathologist/Audiologist: a professional licensed by the State of Nevada Board of Audiology and Speech Pathology and have a current certificate of clinical competence issued by the American Speech and Hearing Association or a comparable body (as per NRS 637B).

1. Provides assessments of enrollees' hearing, speech, and/or language;

2. Develops specialized programs to address communication needs, including speech, reading, auditory training, hearing aid utilization,

and skills in expression, including improvement in articulation, voice, rhythm, and language;

3. Participates in initial care plan development, including specific goals for all enrollees; and

4. Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.

h. Health Education Specialist: a community health worker certified by the Nevada Certification Board, or RN.

1. Provides enrollees with culturally and linguistically appropriate health education to better understand their condition, responsibilities, and health care options;

2. Participates in initial care plan development, including specific goals for all enrollees; and

3. Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.

i. Early Intervention Specialist: a social worker, early childhood special education provider, nurse, or other social services/health care professional with experience providing early intervention services.

1. Evaluates and develops intervention service plans for enrollees under the age of three with disabilities or developmental delays;

2. Provides age-appropriate services (e.g., family training/counseling, nursing services, specialized instruction) in a natural environment (e.g., family home, childcare settings, other places where children usually spend time);

3. Participates in initial care plan development, including specific goals for all enrollees; and

4. Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.

6. Medical Consultant: a physician, physician's assistant, or nurse practitioner (as per NRS 630 and 632 for physician/physician's assistant and nurse practitioner, respectively).

   a. Provides medical consultation to assist the care team in the development of the beneficiary's care plan, participate in team huddles when appropriate, and monitor the ongoing physical aspects of care as needed.

7. Psychiatric Consultant: a licensed psychiatrist, psychiatric advanced practice nurse, psychiatric-certified physician assistant or other QMHPs as cited in MSM Chapter 400.

   a. Provides psychotherapy consult and treatment plan development services;

   b. Communicates treatment methods and expert advice to the Behavioral Health Provider (incorporated into care team); and

   c. Develops the licensed mental health provider's treatment into the patient care plan.

8. Optional Care Team Roles: in addition to the required roles above, the team may also include the other positions depending on the needs of the beneficiary, such as: Education Specialists, Geneticists, and Pharmacists.

C. Required Care Team Staffing-to-Enrollee Ratios: the proceeding table provides the required care team staffing ratios per 50 FASD health home enrollees.

Title	FTE per 50 enrollees
Health Home Director	0.05
Health Home Coordinator	0.13
Care Manager	0.50
Care Manager Extenders	1.00
Specialized HH Consultant	0.13
Medical Consultant	0.05
Psychiatric Consultant	0.05
Total	1.90

4202.6 PROVIDER RESPONSIBILITY

A. The HHPs must meet all components of this policy, the FASD health home State Plan Amendment (SPA), billing guidance, and other requirements as determined by DHCFP.

B. The HHPs will be the primary entities involved in determining eligibility and enrolling beneficiaries in the FASD health homes.

C. The HHPs will coordinate with MCOs for health home enrollees that are members of a MCO for the provision of services covered by the MCO.

D. The HHPs must follow billing and claim requirements as defined in the applicable billing manual (to be created).

E. Applied Behavior Analysis (ABA) Provider Type (PT 85), limited specifically to Specialty 320, is the only PT allowed to enroll and provide FASD health home services.

4203 HEARINGS

Please reference MSM Chapter 3100, Hearings, for hearings procedures.