NV - Submission Package - NV2024MS0002D - Health Homes

CMS-10434 OMB 0938-1188

Package Information

Package ID	NV2024MS0002D	**Submission Type**	Draft
Program Name	Nevada's Health Home for Beneficiaries with FASD	**State**	NV
Version Number	1	**Region**	San Francisco, CA
		Package Status	Pending

Submission - Summary

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Approval Date	N/A	**Effective Date**	N/A
Superseded SPA ID	N/A		

State Information

State/Territory Name:	Nevada	**Medicaid Agency Name:**	State of Nevada DHHS, Division of Health Care Financing & Policy

Submission Component

- (•) State Plan Amendment
- (•) Medicaid
- ( ) CHIP

Submission - Summary

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Executive Summary

Summary Description Including Goals and Objectives

The Nevada Department of Health and Human Services Division of Health Care Financing and Policy (DHCFP) is planning to submit a fetal alcohol spectrum disorder (FASD) State Plan Amendment (SPA) under Section 1945 of the U.S. Social Security Act to establish a Medicaid health home for beneficiaries with FASD. Nevada's 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 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: 1) improve care management of beneficiaries with FASD; 2) increase access to and utilization of evidence-based services for FASD, including but not limited to, applied behavioral analysis (ABA); 3) decrease the onset of behavioral issues that can manifest because of FASD; and (4) to provide services aimed at allowing individuals with FASD to remain in home and community-based settings.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2026	$592065
Second	2027	$816132

Federal Statute / Regulation Citation

1945 of the Social Security Act

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
No items available		

Submission - Summary

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Governor's Office Review

- (●) No comment
- ( ) Comments received
- ( ) No response within 45 days
- ( ) Other

Submission - Medicaid State Plan

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CMS-10434 OMB 0938-1188

The submission includes the following:

- [ ] Administration
- [ ] Eligibility
- [ ] Benefits and Payments
  - [ ] Health Homes Program

Do not use "Create New Health Homes Program" to amend an existing Health Homes program. Instead, use "Amend existing Health Homes program," below.

- ( ) Create new Health Homes program
- ( ) Amend existing Health Homes program
- ( ) Terminate existing Health Homes program

* ( ) Copy from existing Health Homes program

( ) Create new program from blank form

* **Name of Health Homes Program:** Nevada's Health Home for Beneficiaries with FASD

* **This is a SUD-focused program?** ( ) Yes ( ) No

  - [ ] 1945A Health Home Program

Submission - Public Notice/Process

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Name of Health Homes Program

Nevada's Health Home for Beneficiaries with FASD

☐ Public notice was provided due to proposed changes in methods and standards for setting payment rates for services, pursuant to 42 CFR 447.205.

Upload copies of public notices and other documents used

Name	Date Created	
Public Notice to Solicit Public Comment_FASD HH	11/20/2024 1:14 PM EST	

Submission - Tribal Input

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Name of Health Homes Program:

Nevada's Health Home for Beneficiaries with FASD

One or more Indian Health Programs or Urban Indian Organizations furnish health care services in this state

- (•) Yes
- ( ) No

This state plan amendment is likely to have a direct effect on Indians, Indian Health Programs or Urban Indian Organizations, as described in the state consultation plan.

- (•) Yes
- ( ) No

[ ] The state has solicited advice from Indian Health Programs and/or Urban Indian Organizations, as required by section 1902(a)(73) of the Social Security Act, and in accordance with the state consultation plan, prior to submission of this SPA.

Complete the following information regarding any solicitation of advice and/or tribal consultation conducted with respect to this submission:

Solicitation of advice and/or Tribal consultation was conducted in the following manner:

[ ] All Indian Health Programs

Date of solicitation/consultation:	Method of solicitation/consultation:
10/30/2024	Tribal Notification Letter

[ ] All Urban Indian Organizations

Date of solicitation/consultation:	Method of solicitation/consultation:
10/9/2024	Tribal Consultation Meeting
10/30/2024	Tribal Notification Letter

States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation below:

☐ All Indian Tribes

Date of consultation:	Method of consultation:
10/9/2024	Tribal Consultation Meeting
10/30/2024	Tribal Notification Letter

The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.

Name	Date Created	
TC_10-09-24_Agenda_Revised	10/22/2024 4:23 PM EDT	
Tribal_Letter-FASD_HH_(10-30-24)-Signed_ADA	11/20/2024 1:17 PM EST	

Indicate the key issues raised (optional)

☐ Access

☐ Quality

☐ Cost

☐ Payment methodology

☐ Eligibility

☐ Benefits

☐ Service delivery

☐ Other issue

Submission - Other Comment

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SAMHSA Consultation

Name of Health Homes Program

Nevada's Health Home for Beneficiaries with FASD

☐ The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

Date of consultation
11/13/2024

Health Homes Intro

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Program Authority

1945 of the Social Security Act

The state elects to implement the Health Homes state plan option under Section 1945 of the Social Security Act.

Name of Health Homes Program

Nevada's Health Home for Beneficiaries with FASD

Executive Summary

Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used

The Nevada Department of Health and Human Services Division of Health Care Financing and Policy (DHCFP) is planning to submit a fetal alcohol spectrum disorder (FASD) State Plan Amendment (SPA) under Section 1945 of the U.S. Social Security Act to establish a Medicaid health home for beneficiaries with FASD. Nevada's 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 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: 1) improve care management of beneficiaries with FASD; 2) increase access to and utilization of evidence-based services for FASD, including but not limited to, applied behavioral analysis (ABA); 3) decrease the onset of behavioral issues that can manifest because of FASD; and (4) to provide services aimed at allowing individuals with FASD to remain in home and community-based settings.

Nevada's FASD health home model is comprised of designated providers. Designated providers must meet the specific qualifications set forth in the SPA, MSM policy, and provide the six federally required core health home services. Nevada's FASD health home must coordinate with other community-based providers to manage the full breadth of beneficiary needs.

DHCFP will leverage it's Fee-for-Service delivery system to provide this benefit. DHCFP will provide a monthly case rate to a designated provider based on the number of FASD health home beneficiaries receiving at least one FASD health home service during a given month.

General Assurances

- ☐ The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.
- ☐ The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.
- ☐ The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.
- ☐ The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.
- ☐ The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.
- ☐ The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

Health Homes Geographic Limitations

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- (●) Health Homes services will be available statewide
- ( ) Health Homes services will be limited to the following geographic areas
- ( ) Health Homes services will be provided in a geographic phased-in approach

Health Homes Population and Enrollment Criteria

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Categories of Individuals and Populations Provided Health Home Services

The state will make Health Home services available to the following categories of Medicaid participants

☐ Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups

☐ Medically Needy Eligibility Groups

Mandatory Medically Needy

☐ Medically Needy Pregnant Women

☐ Medically Needy Children under Age 18

Optional Medically Needy (select the groups included in the population)

Families and Adults

☐ Medically Needy Children Age 18 through 20

☐ Medically Needy Parents and Other Caretaker Relatives

Aged, Blind and Disabled

☐ Medically Needy Aged, Blind or Disabled

☐ Medically Needy Blind or Disabled Individuals Eligible in 1973

Health Homes Population and Enrollment Criteria

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Population Criteria

The state elects to offer Health Homes services to individuals with:

☐ Two or more chronic conditions

☐ One chronic condition and the risk of developing another

Specify the conditions included:

☐ Mental Health Condition
☐ Substance Use Disorder
☐ Asthma
☐ Diabetes
☐ Heart Disease
☐ BMI over 25
☐ Other (specify):

Name	Description
No items available	

Specify the criteria for at risk of developing another chronic condition:

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

- Abnormal facial features
- Abnormal findings on functional studies of the peripheral nervous system and special senses
- Attention Deficit Hyperactivity Disorder
- Autism Spectrum Disorder
- Cognitive delay
- Conduct disorder
- Chronic serous otitis media
- Expressive language disorder
- Externalizing disorders
- Low body weight
- Special learning disorders
- Pervasive and developmental disorders
- Intellectual disabilities
- Neurobehavioral disorders associated with prenatal exposure to alcohol
- Mood disorders (e.g., depression, anxiety, post-traumatic stress disorder)
- Oppositional Defiant Disorder
- Psychotic disorders
- Receptive language disorder
- Speech and language delays
- Poor coordination
- Vision or hearing problems

☐ One serious and persistent mental health condition

Health Homes Population and Enrollment Criteria

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Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the state will use to enroll eligible Medicaid individuals into a Health Home:

- ○ Opt-In to Health Homes provider
- ○ Referral and assignment to Health Homes provider with opt-out
- ◉ Other (describe)

Name:

2-Tier Enrollment Process

Description:

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

3.2.1. 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 MMIS for the beneficiary.

3.2.2. 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 MCOs.

Health Homes Providers

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Types of Health Homes Providers

☐ Designated Providers

Indicate the Health Homes Designated Providers the state includes in its program and the provider qualifications and standards

☐ Physicians
☐ Clinical Practices or Clinical Group Practices
☐ Rural Health Clinics
☐ Community Health Centers
☐ Community Mental Health Centers
☐ Home Health Agencies
☐ Case Management Agencies
☐ Community/Behavioral Health Agencies
☐ Federally Qualified Health Centers (FQHC)
☐ Other (Specify)

Provider Type	Description
FASD Health Home Provider	The FASD HHP infrastructure will include designated providers working with the care team as described in the "provider infrastructure" section below. FASD health homes must meet requirements cited in the State Plan, state policy, and other guidance established by the State for delivering health home services. To become a designated FASD HHP, an organization will apply to the State demonstrating compliance with FASD health home requirements and experience serving individuals with FASD.

Health Homes Providers

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☐ Teams of Health Care Professionals

☐ Health Teams

Health Homes Providers

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Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

Please see the uploaded document entitled Detailed Provider Infrastructure.

Supports for Health Homes Providers

Describe the methods by which the state will support providers of Health Homes services in addressing the following components

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family- centered Health Homes services
2. Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders
4. Coordinate and provide access to mental health and substance abuse services
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services
8. Coordinate and provide access to long-term care supports and services
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services
10. 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 feasible and appropriate
11. 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 individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level

Description

The state will monitor FASD Health Home providers through reporting and provider enrollment reviews to ensure that Health Home services are being provided that meet the FASD Health Home provider standards and CMS' health home core functional requirements. In addition, the NV FASD Health Homes will be supported as the state continually assesses the FASD Health Homes to determine training needs. FASD Health Homes will participate in a variety of learning supports.

Other Health Homes Provider Standards

The state's requirements and expectations for Health Homes providers are as follows

- Be enrolled as a Nevada Medicaid provider and be in compliance with all applicable program policies;
- Meet and maintain all state requirements for participation, along with all standard provider policies for participation with Medicaid;
- 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);
- Submit an application to the State attesting to meeting HHP requirements;
- 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;
- Submit health home eligibility information for prospective enrollees to the State for enrollment;
- Ensure person-centered and integrated care planning that coordinates and integrates all clinical and non-clinical health care related needs and services;
- Provide quality-driven, cost-effective, and evidence-based health home services in a culturally competent manner that addresses health disparities and improves health literacy;
- Adhere to all provider requirements and all program requirements, and participate in initial Health Home program orientation and subsequent training(s);
- Demonstrate the ability to perform each of the following functional requirements. This includes documentation of the processes and methods used to execute these functions;
  - o Coordinate and provide the six core services cited in Section 2703 of the Affordable Care Act;
  - o Coordinate and provide access to high-quality health care services;
  - o Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
  - o Coordinate and provide access to physical, mental health, and substance use disorder services;
  - o Coordinate and provide access to chronic disease management, including self- management support to individuals and their families;
- 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;
- 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;
- Demonstrate the ability to report required data for both state and federal monitoring of the program.
- Communicate with Medicaid Health Plans to ensure the health plans are aware of which members are enrolled in a health home; and
- Participate in a readiness assessment that includes a gap analysis and mitigation plan.

Name	Date Created	
No items available		

Health Homes Service Delivery Systems

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Identify the service delivery system(s) that will be used for individuals receiving Health Homes services

- [ ] Fee for Service
- [ ] PCCM
- [ ] Risk Based Managed Care
- [ ] Other Service Delivery System

Health Homes Payment Methodologies

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Payment Methodology

The State's Health Homes payment methodology will contain the following features

- [ ] Fee for Service
  - [ ] Individual Rates Per Service
  - [x] Per Member, Per Month Rates
  - [x] Fee for Service Rates based on
    - [ ] Severity of each individual's chronic conditions
    - [x] Capabilities of the team of health care professionals, designated provider, or health team
    - [ ] Other
  - [ ] Comprehensive Methodology Included in the Plan
  - [ ] Incentive Payment Reimbursement

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided: There are no variations

- [ ] PCCM (description included in Service Delivery section)
- [ ] Risk Based Managed Care (description included in Service Delivery section)
- [ ] Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

Health Homes Payment Methodologies

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Agency Rates

Describe the rates used

- ○ FFS Rates included in plan
- ○ Comprehensive methodology included in plan
- ◉ The agency rates are set as of the following date and are effective for services provided on or after that date

Effective Date

4/1/2025

Website where rates are displayed

https://dhcfp.nv.gov/Resources/Rates/RATESMAIN/

Health Homes Payment Methodologies

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Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates;
2. Please identify the reimbursable unit(s) of service;
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit;
4. Please describe the state's standards and process required for service documentation, and;
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including:
    - the frequency with which the state will review the rates, and
    - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description

DHCFP will provide a monthly fee-for-service case rate to the Health Home Provider based on the number of FASD HH beneficiaries with at least one of the six core FASD HH services in a month that are not duplicative of other Nevada Medicaid-covered services. Health Home Providers will bill for FASD HH services directly to the State, regardless of whether the enrollee is enrolled with a MCO or in fee-for-service Medicaid. For Medicaid-covered services outside the six core FASD HH services, providers will bill and be reimbursed in accordance with current Nevada Medicaid FFS or MCO policies.

The monthly case rate was established using the Health Home Provider infrastructure at the level of efforts described in Section 4 above. This included utilizing wage and benefit information from the US Bureau of Labor Statistics. The monthly case rate will be updated as needed based upon elements such as beneficiary enrollment, claims experience, and economic factors. DHCFP reserves the right to update the case rate as necessary and appropriate. Providers much check a beneficiary's Medicaid eligibility frequently to ensure FASD HH services will be covered by Medicaid. Additionally, the provider is responsible for completing the FASD HH eligibility and enrollment as previously outlined, including a signed consent to participate.

Health Homes Payment Methodologies

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Assurances

☐ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

Describe below how non-duplication of payment will be achieved

Health Home service payments will not result in any duplication of payment or services between Medicaid programs, services, or benefits (i.e., TCM, HCBS Waivers, managed care, other delivery systems including waivers, any future Health Home state plan bene ts, and other state plan services). In addition to offering guidance to providers regarding this restriction, the State may periodically examine recipient files to ensure that Health Home individuals are not receiving similar services through other Medicaid-funded programs.

The State and HHPs will be the primary entities involved in determining eligibility and enrolling beneficiaries in the FASD health homes. The State will directly reimburse HHPs for FASD health home services. Nevada's MCOs will have a limited role in health home enrollment and service provision, focusing specifically on coordination with HHPs. MCOs will identify their beneficiary members who may benefit from FASD health home services and refer those individuals to their nearest HHP for eligibility determination. MCOs will not duplicate services of the FASD Health Home. For members enrolled in the FASD Health Home, the MCO will coordinate with FASD Health Home providers to ensure access to, and the provision of services covered under the MCO contract.

☐ The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).

☐ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

☐ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

Name	Date Created	
No items available		

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | NV2024MS0002D | Nevada's Health Home for Beneficiaries with FASD

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Service Definitions

Provide the state's definitions of the following Health Homes services and the specific activities performed under each service

Comprehensive Care Management

Definition

Comprehensive care management is 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. Comprehensive care management includes, but is not limited to:

- Outreach and engagement activities to gather information from the enrollee, the enrollee's support member(s), and other primary and specialty care providers;
- Assessment of each enrollee, including behavioral and physical health care needs;
- Development of a comprehensive person-centered care plan;
- Documentation of the assessment and care plan in the Electronic Health Record (EHR);
- Periodic reassessment of each beneficiary's treatment, outcomes, goals, self- management, health status, and service utilization in relation to the health home;
- Chronic care management (e.g., management of multiple chronic conditions); and
- Management of unmet health-related resource needs and high-risk social environments.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

The state maintains various Health Information Technology (HIT) systems that will be used to improve service delivery and care coordination across the care continuum. One feature the state is exploring is to build out the treatment history function module to support understanding of an individual's past diagnostic and treatment history.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Provider Type	Description
FASD Health Home Providers	The FASD HHP infrastructure will include designated providers working with the care team as described in the "provider infrastructure" section. FASD health homes must meet requirements cited in the State Plan, state policy, and other guidance established by the State for delivering health home services. To become a designated FASD HHP, an organization will apply to

Provider Type	Description
	the State demonstrating compliance with FASD health home requirements and experience serving individuals with FASD.

Health Homes Services

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Care Coordination

Definition

Care coordination is the facilitation of access to, and the monitoring of, services identi ed 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. Care coordination includes, but is not limited to:

- Ensuring the enrollee has an ongoing source of care;
- Implementing the person-centered care plan;
- Management of all integrated primary and specialty medical services, behavioral and physical health services, and developmental, social, educational, vocational, housing, and community services;
- 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;
- Supporting the enrollee's adherence to prescribed treatment regimens (including medication-assisted treatment) and wellness activities, including medication adherence and monitoring;
- Participating in the hospital discharge processes to support the enrollee's transition to a non-hospital setting and requiring discharge summaries;
- Communicating, information sharing, and consulting with other providers and the enrollee and enrollee's authorized representative(s), and family, as appropriate;
- Facilitating regularly scheduled interdisciplinary team meetings to review care plans and assess progress;
- Providing assistance with making appointments, including coordinating transportation;
- Tracking referral;
- Tracking enrollee test results; and
- Connecting enrollees to resources (e.g., smoking cessation, substance use disorder treatment, nutritional counseling, obesity reduction and prevention, disease-specific education, etc.).

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

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Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
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- [ ] Pharmacists
- [ ] Social Workers
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- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Provider Type	Description
FASD Health Home Provider	The FASD HHP infrastructure will include designated providers working with the care team as described in the "provider infrastructure" section. FASD health homes must meet requirements cited in the State Plan, state policy, and other guidance established by the State for delivering health home services. To become a designated FASD HHP, an organization will apply to the State demonstrating compliance with FASD health home requirements and experience serving individuals with FASD.

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Health Promotion

Definition

Health promotion is 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. Health promotion includes, but is not limited to:

- Promoting enrollees' and their families' education on their chronic condition (e.g., diabetes education, nutrition education);
- Promoting health lifestyle interventions;
- Encouraging routine preventative care such as immunizations and screenings;
- Conducting medication reviews and regimen compliance;
- Assessing the patient's and family's understanding of the health condition and motivation to engage in self-management;
- 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
- Using evidence-based practices to engage and help enrollees participate in and manage their care.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

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Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses
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Provider Type	Description
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Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

Definition

Comprehensive transitional care is 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 health home provider. 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. Comprehensive transitional care and follow-up includes, but is not limited to:

- 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.
  - 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.
- 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.
- 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.
- Developing a systemic protocol to assure timely access to follow-up care post discharge that includes, at a minimum, all of the following:
  - Receipt of a summary of care record from the discharging entity;
  - Medication reconciliation;
  - Pharmacy coordination;
  - Reevaluation of the care plan to include and provide access to needed community support services; and
  - A plan to ensure timely scheduled appointments.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

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Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses
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- [ ] Physicians
- [ ] Physician's Assistants
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- [ ] Dieticians
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Provider Type	Description
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Provider Type	Description
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Individual and Family Support (which includes authorized representatives)

Definition

Individual and family supports involves 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. Individual and family support services include, but are not limited to:

- Providing education and guidance in support of self-advocacy;
- 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;
- Identifying resources to assist enrollees and family support members in acquiring, retaining, and improving self-help, socialization, and adaptive skills; and
- Providing information and assistance in accessing services such as self-help, peer support , and respite.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

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Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
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Referral to Community and Social Support Services

Definition

Referral to community and social supports involves 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 identi ed on the enrollee's person-centered care plan. Referral services include, but are not limited to:

- Providing referral and information assistance to individuals on obtaining community-based resources and social support services, including substance use disorder supports, disability benefits (e.g., SSI/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;
- Identifying resources to reduce barriers to help individuals achieve their highest level of function and independence; and
- 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.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

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Health Homes Patient Flow

Describe the patient flow through the state's Health Homes system. Submit with the state plan amendment flow-charts of the typical process a Health Homes individual would encounter

Please see the uploaded file named FASD Health Home Patient Flow

Name	Date Created	
FASD Health Home Patient Flow	10/22/2024 4:47 PM EDT	

Health Homes Monitoring, Quality Measurement and Evaluation

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Monitoring

Describe the state's methodology for calculating cost saving (and report cost savings annually in Quality Measure Report). Include savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates:

DHCFP will conduct a cost-efficiency analysis for the FASD Health Home program. Broadly, the cost-focused analyses will consider the consequences of improved care coordination and clinical management for beneficiaries enrolled in the program and will also measure total expenditures for individuals enrolled in the program comparing the implementation period with the period immediately prior to program implementation. In addition to the pre-post comparison, the evaluation may also compare total expenditures for beneficiaries enrolled in the intervention (program) with expenditures for a concurrent control population identified on the basis of their specific eligible conditions and receipt of care. Nevada will use administrative claims data for this analysis. Adjustments will be made for cost outliers in the analysis.

Describe how the state will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

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Health Homes Monitoring, Quality Measurement and Evaluation

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Quality Measurement and Evaluation

- [ ] The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state.
- [ ] The state provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.
- [ ] The state provides assurance that it will report to CMS information to include applicable mandatory Core Set measures submitted by Health Home providers in accordance with all requirements in 42 CFR §§ 437.10 through 437.15 no later than state reporting on the 2024 Core Sets, which must be submitted and certified by December 31, 2024 to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS. In subsequent years, states must report annually, by December 31st, on all measures on the applicable mandatory Core Set measures that are identified by the Secretary.
- [ ] The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report.

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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