4000 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.

4001 AUTHORITY

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

Statutes and Regulations:

- Social Security Act: 1915(i) (1)(a) through (j)
- Code of Federal Regulations (CFR)
    - 42 CFR 441.710 State Plan Home and Community-Based Services under Section 1915(i)(1) of the Act
    - 42 CFR 441.715 Needs-Based Criteria and Evaluation
    - 42 CFR 441.720 Independent Assessment
    - 42 CFR 441.725 Person-Centered Service Plan
    - 42 CFR 441.730 Provider Qualifications
- Nevada Revised Statutes (NRS) Chapter 424
- Nevada Administrative Code (NAC) Chapter 424

4002 RESERVED

4003 POLICY

4003.1 NEEDS BASED ELIGIBILITY CRITERIA

The DHCFP 1915(i) Home and Community-Based Services (HCBS) State Plan Option utilizes a needs-based criteria to evaluate and reevaluate whether an individual is eligible for services. The criteria considers the individual's support needs and risk factors.

Children/youth must need minimum requirements to be considered for 1915(i) services:

A. Impaired Functioning & Service Intensity: The Case Manager/Wraparound Facilitator (CM/WF) and Child and Family Team (CFT) will use a comprehensive biopsychosocial assessment and the level of care decision support tools the Early Childhood Service Intensity Instrument (ECSII) for youth ages 0-5 or the Child and Adolescent Service Intensity Instrument (CASII) for youth ages 6-18. The Wraparound Facilitator and CFT will review clinical indicators of impaired functioning: Prior psychological assessment records, prior placement history, and prior treatment history. Youth must demonstrate significant levels of behavioral health needs as evidenced by Serious Emotional Disturbance (SED) determination; and must demonstrate a minimum CASII or ECSII level of 1; and

B. Other Community Alternatives: The accessibility and/or intensity of currently available community supports and services are inadequate to meet these needs due to the severity of the impairment without the provision of one or more of the services contained in the HCBS Benefit, as determined by the Division of Child and Family Services (DCFS) or its designee as evidenced by at least one of the following risk factors:

   1. At risk of higher level of care placement due to recent placement disruption within the past six months;

   2. Current placement in emergency shelter or congregate care due to behavioral and mental health needs;

   3. In need of transition to community-based living arrangement with intensive behavioral supports when returning or stepping down from residential treatment center or other higher level of care placement; and/or

   4. At risk of higher level of care placement because prior less restrictive placements or interventions, such as traditional family foster care and/or community treatment services, have not been successful.

4003.2A COVERAGE AND LIMITATIONS

1. PROGRAM ELIGIBILITY

   a. A youth must meet and maintain Medicaid eligibility.

b. Youth must be under 19 years of age at the time of enrollment; they may continue in HCBS benefit through age 19.

c. Youth must have a Diagnostic and Statistical Manual of Mental Disorders (DSM-5) or Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-3) diagnosis.

d. A youth must meet the needs-based eligibility requirements.

e. The youth must reside in the Nevada licensed specialized foster home-based setting not considered an institutional level setting.

2. COVERED SERVICES

a. Intensive In-Home Supports and Services

b. Crisis Stabilization Services

3. NON-COVERED SERVICES

The following services are not covered benefits under 1915(i) HCBS State Plan option and are therefore not reimbursable:

a. Services rendered to a youth who is not eligible for Nevada Medicaid.

b. Services rendered to a youth who no longer meets the needs-based eligibility criteria.

c. Services rendered to a youth who is no longer in the Nevada licensed specialized foster home-based setting but is institutionalized (hospital, residential treatment center, or detained/incarcerated.

d. Services rendered to an individual over the age of 19.

e. Services rendered to an individual over the age of 18 and not enrolled in high school.

f. Services rendered to a youth for which the State of Nevada or county child welfare jurisdiction; Clark County Department of Family Services (CCDFS), Washoe County Human Services Agency (WCHSA) is no longer the legal custodian and who are no longer admitted in the specialized foster care program.

g. Services rendered to a youth that does not have a Diagnostic and Statistical Manual of Mental Disorders (DMS-5) or Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-3) diagnosis.

4003.3B PROVIDER RESPONSIBILITIES

1. PROVIDER QUALIFICATION

In addition to this chapter, providers must also comply with rules and regulations for providers as set forth in the MSM Chapter 100. Each 1915(i) service outlines specific provider qualifications which must be adhered to in order to render that 1915(i) service.

2. MEDICAID ELIGIBILITY

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. 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).

4. NOTIFICATION OF SUSPECTED ABUSE OR NEGLECT

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

5. SERIOUS OCCURRENCE REPORT (SOR)

Child welfare jurisdictions and agencies shall adhere to the requirements of NAC 424.476 in reporting any serious incident, accident, or injury to a child involving a foster home or a child in a foster home to the licensing authority and any caseworker assigned to the child. Jurisdictions/agencies should refer to NAC 424.476 in determining specific incidents, accidents, and injuries that must be reported.

6. DOCUMENTATION STANDARDS

a. Assessment

1. There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

2. Based on the independent assessment, there is a person-centered plan of care for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-

centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

3. The person-centered plan of care is reviewed and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

4. The Case Managers (CM)/Wraparound Facilitators (WF)must be independent of the Specialized Foster Care Agency

5. All WF will be required to be certified by DCFS as a Wraparound Facilitator utilizing the standards of the National Wraparound Implementation Center. All CM will be required to be trained by DCFS in the FOCUS model utilizing the standards of the National Wraparound Implementation Center.

6. All CM and WF will be required to maintain appropriate certifications including certification on the Nevada Child and Adolescent Needs and Strengths tool (NV-CANS). Recipients will receive either services of CM or WF based on level of need.

b. Person-centered Plan of Care (POC)

1. The development of the person-centered POC will focus on a strengths and needs-driven approach that provides intensive care management in a team setting using a Child and Family Team (CFT) approach. The CFT team includes the CM/WF, child or youth, caregiver(s), support persons identified by the family (paid and unpaid), and service providers, including the youth's treating clinician as available.

2. The process is designed to promote youth and parent involvement as active members of the CFT. The goals of CFT meetings are to manage care and services to avoid fragmentation, ensure access to appropriate and person-centered care, and provide a team approach to address needs. Youth and parent/guardian involvement is essential in the assessment of: safety; strengths; medical, social, behavioral, educational and cultural needs; skill building; family/caregiver supports and services; and goals.

3. The CM/WF will utilize assessments to create the person-centered POC for children and families. The plan will include needs, outcomes, and strategies that are:

a. Specific. The CFT, including the family should know exactly what must be completed or changed and why.

b. Measurable. Everyone should know when the needs have been met. Outcomes will be measurable to the extent that they are behaviorally based and written in clear and understandable language.

c. Achievable. The CFT and family should be able meet the identified needs in a designated time period given the resources that are accessible and available to support change.

4. The person-centered POC will include detailed service plans for applicable 1915(i) services. The CFT shall develop the initial POC, which will be documented by the CM/WF. The CM/WF will also be responsible for documenting updates to the POC, including recommendations and decisions made by the CFT, in accordance to timeframes as listed in DCFS policy.

5. The CM/WF is responsible to submit the developed POC to the QIO-like vendor for approval.

c. Progress Notes: Progress notes for all BH services including RMH and OMH services are the written documentation of treatment services, or services coordination provided to the recipient pursuant to the Treatment Plan, which describes the progress, or lack of progress towards the goals and objectives of the Treatment Plan.

1. All progress notes documented with the intent of submitting a billable Medicaid behavioral health service claim must be documented in a manner that is sufficient to support the claim and billing of the services provided and must further document the amount, scope and duration of the service(s) provided as well as identify the provider of the service(s).

2. A Progress Note is required for each day the service was delivered, must be legible and must include the following information:

a. The name of the individual receiving the service(s). If the services are in a group setting, it must be indicated;

b. The place of service;

c. The date the service was delivered;

d. The actual beginning and ending times the service was delivered;

e. The name of the provider who delivered the service;

f. The credentials of the person who delivered the service;

g. The signature of the provider who delivered the service;

h. The goals and objectives that were discussed and provided during the time the services were provided; and

i. A statement assessing the recipient's progress towards attaining the identified treatment goals and objectives requested by the QMHP.

3. Temporary, but clinically necessary, services do not require an alteration of the treatment plan; however, these types of services, and why they are required, must be identified in a progress note. The note must follow all requirements for progress notes as stated within this section.

7. 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 custodian of the child will:

a. Notify the provider(s) and CM/WF of a change in Medicaid eligibility.

b. Notify the provider(s) and CM/WF of changes in medical status, service needs or changes of status of designated representative.

c. Initial and/or sign the provider service documentation logs as applicable, verifying services were rendered unless otherwise unable to perform this task due to cognitive and/or physical limitations.

d. Notify the CM/WF if services are no longer requested or required.

e. Notify the provider(s) and the CM/WF of unusual occurrences, complaints regarding delivery of services or specific staff.

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

g. Contact the CM/WF to request a change of provider.

4003.4 INTENSIVE IN-HOME SERVICES

4003.4A COVERAGE AND LIMITATIONS

1. Evidence-based interventions that target emotional, cognitive, and behavioral functioning within a variety of actual and/or simulated social settings. Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence. Services focus on enabling the participant to attain or maintain

his or her maximum potential and shall be coordinated with needed behavioral and physical health services and supports in the participant's person-centered services and support plans.

2. Regular support and technical assistance to the treatment parents in their implementation of the POC and with regard to other responsibilities they undertake. The fundamental components of technical assistance are the design or revision of in-home treatment strategies including proactive goal setting and planning, the provision of ongoing child-specific skills training and the problem-solving during home visits.

3. Assessing behavioral problems and the functions of these problems and related skill deficits and assets, including identifying primary and other important caregiver skill deficits and assets related to the youth's behaviors and the interactions that motivate, maintain, or improve behavior.

4. The amount, frequency and duration of this service is based on the participant's assessed needs and documented in the approved POC. Eligible setting includes the child's home.

   a. Service Limitations: Intensive In-Home Services and Supports Without Coaching – Provided in-home by the treatment foster parent(s). Maximum of two hours per day, seven days a week.

   b. Service Limitations: Intensive In-Home Services and Supports with Coaching – Provided in-home by a trained coach supporting the treatment foster parent(s) to deliver evidence-based interventions to fidelity. Maximum of one hour per week.

5. Intensive In-Home services cannot be reimbursed if billed in conjunction with as Psychosocial Rehabilitation (PSR) and Basic Skills Training (BST).

4003.4B PROVIDER QUALIFICATIONS

1. Intensive Home-based provider/individual

   a. Individuals must be trained in State evidence-based model through the DCFS.

   b. Must meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to DHCFP Medicaid Services Manual, Chapter 100.

   c. Must meet all Conditions of Participation in Medicaid Services Manual 102.1.

2. Specialized Foster Care Agency

   a. Pursuant to NRS 424, an application for a license to operate a foster care agency must be in a form prescribed by the Division and submitted to the appropriate licensing authority.

   b. Agencies must be certified in State evidence-based model through the DCFS.

c. Agencies must meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to DHCFP Medicaid Services Manual, Chapter 100.

d. Agencies must meet all Conditions of Participation in Medicaid Services Manual 102.1.

e. Agencies must meet all applicable standards listed in NAC 424 and NRS 424.

3. Child Welfare Jurisdiction

a. Meet licensure requirements pursuant to DHCFP Medicaid Services Manual.

b. Must be certified in State evidence-based model through the DCFS.

c. Meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to DHCFP Medicaid Services Manual, Chapters 100 and 400.

d. The individual providing the coaching will meet the requirements determined through the DCFS.

4003.4C NON-COVERED SERVICES

Intensive In-Home services do not include (from CMS 2261-P):

1. Intensive In-Home services are not custodial care benefits for individuals with chronic conditions but should result in a change in status;

2. Custodial care and/or routine supervision: Age and developmentally appropriate custodial care and/or routine supervision including monitoring for safety, teaching or supervising hygiene skills, age appropriate social and self-care training and/or other intrinsic parenting and/or care giver responsibilities;

3. Maintaining level of functioning: Services provided primarily to maintain a level of functioning in the absence of intensive in-home goals and objectives, impromptu non-crisis interventions and routine daily therapeutic milieus;

4. Case management: Conducting and/or providing assessments, care planning/ coordination, referral and linkage and monitoring and follow-up;

5. Habilitative services;

6. Services provided to individuals with a primary diagnosis of intellectual disabilities and related conditions (unless these conditions co-occur with a mental illness) and which are not focused on rehabilitative mental and/or behavioral health;

7. Cognitive/intellectual functioning: Recipients with sub-average intellectual functioning who would distinctly not therapeutically benefit from RMH services;

8. Transportation: Transporting recipients to and from medical and other appointments/services;

9. Educational, vocational or academic services: General and advanced private, public and compulsory educational programs; personal education not related to the reduction of mental and/or behavioral health problem; and services intrinsically provided through the Individuals with Disabilities Education Improvement Act (IDEA);

10. Inmates of public institutions: To include detention facilities, forestry camps, training schools or any other facility operated primarily for the detention of children who are determined to be delinquent;

11. Room and board: Includes housing, food, non-medical transportation and other miscellaneous expenses, as defined below:

    a. Housing expenses include shelter (mortgage payments, rent, maintenance and repairs and insurance), utilities (gas, electricity, fuel, telephone and water) and housing furnishings and equipment (furniture, floor coverings, major appliances and small appliances);

    b. Food expenses include food and nonalcoholic beverages purchased at grocery, convenience and specialty store;

    c. Transportation expenses include the net outlay on purchase of new and used vehicles, gasoline and motor oil, maintenance and repairs and insurance;

    d. Miscellaneous expenses include clothing, personal care items, entertainment and reading materials;

    e. Administrative costs associated with room and board;

12. Non-medical programs: Intrinsic benefits and/or administrative elements of non- medical programs, such as foster care, therapeutic foster care, child welfare, education, childcare, vocational and prevocational training, housing, parole and probation and juvenile justice;

13. Services under this chapter for a recipient who does not have a covered, current ICD diagnosis;

14. Any type of psychotherapy services;

15. Respite care;

16. Recreational activities: Recreational activities not focused on rehabilitative outcomes;

17. Personal care: Personal care services intrinsic to other social services and not related to RMH goals and objectives;

4003.5 CRISIS STABILIZATION SERVICES

Crisis Stabilization services are short-term, outcome-oriented, and of higher intensity than other behavioral interventions that are designed to provide interventions focused on developing effective behavioral management strategies to secure participant and family/caregiver's health and safety following a crisis. These services may only be delivered in an individual, one-to-one session and are available in the child's home. The service is short-term designed to achieve community stabilization through psychoeducation, crisis stabilization, and crisis resolution support. The service is of high intensity with the intent to develop effective behavioral strategies that will be maintained and help the child to sustain the behavioral strategies long-term.

4003.5A COVERAGE AND LIMITATIONS

1. The amount, frequency and duration of this service is based on the participant's assessed needs and documented in the approved POC.
2. This service is not subject to Prior Authorization requirements.
3. Crisis Stabilization services may only be delivered in an individual, one-to-one session and are available in the child/youth's home.
4. The maximum number of service hours per day is four hours for up to 40 hours per month. Post authorization request required beyond 40 hours. Additional units of services may be authorized by the DHCFP or designee on post authorization review.

4003.5B PROVIDER QUALIFICATIONS

1. Specialized Foster Care Agency
   a. Pursuant to NRS 424, an application for a license to operate a foster care agency must be in a form prescribed by the Division and submitted to the appropriate licensing authority.
   b. Foster Care Agency providers must be enrolled as a Foster Care Provider Agency through DHCFP's fiscal agent and meet all required standards listed in the DHCFP Medicaid Services Manual.
   c. Agencies must meet all applicable standards listed in NAC 424 and NRS 424.
2. Child Welfare Jurisdiction
   a. Meet licensure requirements pursuant to DHCFP Medicaid Services Manual.
   b. Meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to the DHCFP Medicaid Services Manual, Chapters 100 and 400.

4003.5C NON-COVERED SERVICES

Crisis Stabilization services do not include:

1. When a youth's behavior no longer requires immediate and intensive interventions to help stabilize the current situation and prevent hospitalization;

2. When a youth no longer presents a moderate risk of danger to themselves and others;

3. When a youth's behavior becomes manageable and no longer requires stabilization;

4. Crisis stabilization services are not custodial care benefits for individuals with chronic conditions but should result in a change in status;

5. Custodial care and/or routine supervision: Age and developmentally appropriate custodial care and/or routine supervision including monitoring for safety, teaching or supervising hygiene skills, age appropriate social and self-care training and/or other intrinsic parenting and/or care giver responsibilities;

6. Maintaining level of functioning: Services provided primarily to maintain a level of functioning in the absence of crisis stabilization goals and objectives, impromptu non-crisis interventions and routine daily therapeutic milieus;

7. Case management: Conducting and/or providing assessments, care planning/ coordination, referral and linkage and monitoring and follow-up;

8. Habilitative services;

9. Services provided to individuals with a primary diagnosis of intellectual disabilities and related conditions (unless these conditions co-occur with a mental illness) and which are not focused on rehabilitative mental and/or behavioral health;

10. Cognitive/intellectual functioning: Recipients with sub-average intellectual functioning who would distinctly not therapeutically benefit from RMH services;

11. Transportation: Transporting recipients to and from medical and other appointments/services;

12. Educational, vocational or academic services: General and advanced private, public and compulsory educational programs; personal education not related to the reduction of mental and/or behavioral health problem; and services intrinsically provided through the Individuals with Disabilities Education Improvement Act (IDEA);

13. Inmates of public institutions: To include detention facilities, forestry camps, training schools or any other facility operated primarily for the detention of children who are

determined to be delinquent;

14. Room and board: Including housing, food, non-medical transportation and other miscellaneous expenses, as defined below:

    a. Housing expenses include shelter (mortgage payments, rent, maintenance and repairs and insurance), utilities (gas, electricity, fuel, telephone and water) and housing furnishings and equipment (furniture, floor coverings, major appliances and small appliances);

    b. Food expenses include food and nonalcoholic beverages purchased at grocery, convenience and specialty store;

    c. Transportation expenses include the net outlay on purchase of new and used vehicles, gasoline and motor oil, maintenance and repairs and insurance;

    d. Miscellaneous expenses include clothing, personal care items, entertainment and reading materials;

    e. Administrative costs associated with room and board;

15. Non-medical programs: Intrinsic benefits and/or administrative elements of non- medical programs, such as foster care, therapeutic foster care, child welfare, education, childcare, vocational and prevocational training, housing, parole and probation and juvenile justice;

16. Services under this chapter for a recipient who does not have a covered, current ICD diagnosis;

17. Any type of psychotherapy services;

18. Respite care;

19. Recreational activities: Recreational activities not focused on rehabilitative outcomes;

20. Personal care: Personal care services intrinsic to other social services and not related to RMH goals and objectives;

4004 PRIOR AUTHORIZATION

There are no prior authorization requirements for Intensive In-Home services. The service limitations for Intensive In-home services are listed above. There are no prior authorization requirements for Crisis Stabilization services. The service limitations for Crisis Stabilization services are listed above. Additional units of services may be authorized by DHCFP or designee on post authorization review**.**

4005 HEARINGS

Please reference MSM, Chapter 3100, for Hearings process and policy.