



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Region IX

Division of Medicaid & Children's Health Operations

90 Seventh Street, Suite 5-300 (5W)

San Francisco, CA 94103-6706

OCT 31 2008

Michael J. Willden, Director
Department of Health and Human Services
4126 Technology Way, Room 100
Carson City, Nevada 89706-2009

Dear Mr. Willden:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed amendment to Attachments 3.1-G and 4.19-B of your Medicaid State plan for Home and Community Based Services (HCBS) submitted under transmittal number 07-003. This State plan amendment (SPA) provides for expanded access to HCBS to Medicaid beneficiaries who meet specified needs-based HCBS eligibility criteria. Enclosed is an approved copy of the SPA.

I am approving this SPA with the requested effective date of November 1, 2008. This amendment is notable in that, after Iowa, Nevada is the second State to have a SPA approved under Section 1915(i) of the Social Security Act. We appreciate the State's diligence and patience in working with CMS to make the SPA approvable. Upon publication of the final regulations concerning Section 1915 (i), Nevada would need to come into compliance with any requirements imposed by the final regulations.

If you have any questions, please contact Ronald Reepen of my staff at (415) 744-3601, or e-mail him at Ronald.Reepen@cms.hhs.gov.

Sincerely,

A handwritten signature in cursive script, appearing to read "Gloria Nagle".

Gloria Nagle
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure

Page 2 – Michael J. Willden

cc: Christopher Thompson, CMSO
Michelle Bowser, CMSO (2)
Ellen Blackwell, CMSO
Charles Duarte, Administrator, DHCFP
John Liveratti, DHCFP

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:
07-003

2. STATE
NEVADA

FOR: HEALTH CARE FINANCING ADMINISTRATION

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
~~July 1, 2007~~ November 1, 2008
HJM

5. TYPE OF PLAN MATERIAL (Check One):

- NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:
Title XIX of Social Security Act - Section 1915(i)

7. FEDERAL BUDGET IMPACT:

a. FFY 2007 \$0
b. FFY 2008 \$0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1-G Pages 1-41b
Attachment 4.19-B Pages ~~10-19~~ 11-19 HJM
Attachment 4.19-B, Assurances

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

Attachment 4.19-B Pages 11-19
~~10-19~~ HJM

10. SUBJECT OF AMENDMENT:

Addition of 1915(i) Home and Community Based State Plan Services

11. GOVERNOR'S REVIEW (Check One):

- GOVERNOR'S OFFICE REPORTED NO COMMENT
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

OTHER, AS SPECIFIED:
The Governor's Office does not
wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Michael J. Willden

14. TITLE:
Director, Department of Health & Human Services

15. DATE SUBMITTED:
MAR 20 2007

16. RETURN TO:

John A. Liveratti, Chief
DHCFF/Medicaid
1100 East William Street, Suite 101
Carson City, NV 89701

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
March 21, 2007

18. DATE APPROVED: OCT 31 2008

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
November 1, 2008

20. SIGNATURE OF REGIONAL OFFICIAL:
Gloria Nagle

21. TYPED NAME:

Gloria Nagle

22. TITLE: Associate Regional Administrator
Div. of Medicaid & Children's Health Ops

23. REMARKS:

§1915(i) Home and Community Based Services (HCBS) State Plan Services
ADMINISTRATION AND OPERATION

1. **Program Title:** **NEVADA 1915(i) STATE PLAN HOME AND COMMUNITY BASED SERVICES** - Including Adult Day Health, HCBS Home-Based Habilitation and HCBS Partial Hospitalization.

§1915(i) Home and Community Based Services (HCBS) State Plan Services
ADMINISTRATION AND OPERATION

2. State-wideness:

- The State implements this supplemental benefit package statewide, per §1902(a)(1) of the Act.
- The State implements this benefit without regard to the state wideness requirements in §1902(a)(1) of the Act.:
 - Geographic Limitation.** HCBS state plan services will only be available to individuals who reside in the following geographic areas or political subdivisions of the State.:
 - Limited Implementation of Participant-Direction.** HCBS state plan services will be implemented without regard to state-wideness requirements to allow for the limited implementation of participant-direction. Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the State. Individuals who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.:

§1915(i) Home and Community Based Services (HCBS) State Plan Services
ADMINISTRATION AND OPERATION

3. State Medicaid Agency (SMA) Line of Authority for Operating the HCBS State Plan Supplemental Benefit Package:

The HCBS state plan supplemental benefit package is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program (*select one*):

The Medical Assistance Unit: **Division of Health Care Financing and Policy**

Another division/unit within the SMA that is separate from the Medical Assistance Unit

The HCBS state plan supplemental benefit package is operated by: a separate agency of the State that is not a division/unit of the Medicaid agency. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.

§1915(i) Home and Community Based Services (HCBS) State Plan Services
ADMINISTRATION AND OPERATION

4. Distribution of State Plan HCBS Operational and Administrative Functions.

The State assures that in accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration or supervision of the state plan. When a function is performed by other than the Medicaid agency, the entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities.:

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Disseminate information concerning the state plan HCBS to potential enrollees	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> Other divisions of the State Department of Health and Human Services	<input checked="" type="checkbox"/> QIO-like agency	<input checked="" type="checkbox"/> Providers
2 Assist individuals in state plan HCBS enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> Other divisions of the State Department of Health and Human Services	<input type="checkbox"/>	<input checked="" type="checkbox"/> Providers
3 Manage state plan HCBS enrollment against approved limits, if any	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 Review participant service plans to ensure that state plan HCBS requirements are met	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> QIO-like agency	<input checked="" type="checkbox"/> Providers
5 Recommend the prior authorization of state plan HCBS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> QIO-like agency	<input checked="" type="checkbox"/> Providers
6 Conduct utilization management functions	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> QIO-like agency	<input type="checkbox"/>
7 Recruit providers	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> QIO-like agency	<input type="checkbox"/>
8 Execute the Medicaid provider agreement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> QIO-like agency	<input type="checkbox"/>
9 Conduct training and technical assistance concerning state plan HCBS requirements	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> QIO-like agency	<input type="checkbox"/>
10 Conduct quality monitoring of individual health and welfare and State plan HCBS program performance.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> QIO-like agency	<input checked="" type="checkbox"/> Providers

For items 1. and 2., the Nevada Divisions for Aging Services (DAS), Division of Child and Family Services (DCFS), and Mental Health and Developmental Services (MHDS) as well the office of Disability Services (ODS) will assist in disseminating information concerning the state plan HCBS and enrolling potential recipients.

§1915(i) Home and Community Based Services (HCBS) State Plan Services
ADMINISTRATION AND OPERATION

For items 1., 4., 5., 6., 7., 8., 9. and 10., the Medicaid Fiscal Intermediary which is the QIO-like agency in Nevada will serve as the contracted entity.

For item 10, the Nevada Divisions of Aging Services (DAS), Division of Child and Family Services (DCFS), and Mental Health and Developmental Services (MHDS) as well the Office of Disability Services (ODS) will assist in disseminating information concerning the state plan HCBS and enrolling potential recipients.

§1915(i) Home and Community Based Services (HCBS) State Plan Services

ADMINISTRATION AND OPERATION

5. **Conflict of Interest Standards.** The State assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual, or any paid caregiver of the individual
- financially responsible for the individual
- empowered to make financial or health-related decisions on behalf of the individual
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except at the option of the State, for performance of assessments and plan of care only, when such individuals are the only willing and qualified provider in a geographic area, and the State devises conflict of interest protections.

The individual performing assessment, eligibility, and plan of care must be an independent third party.

§1915(i) Home and Community Based Services (HCBS) State Plan Services
ADMINISTRATION AND OPERATION

6. **Appeals.** The State allows for appeals in accordance with 42 CFR 431 Subpart E.

§1915(i) Home and Community Based Services (HCBS) State Plan Services
ADMINISTRATION AND OPERATION

7. **No FFP for Room and Board.** The State has methodology to prevent claims for Federal financial participation for room and board in HCBS state plan services.

§1915(i) Home and Community Based Services (HCBS) State Plan Services
NUMBER SERVED

8. **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities. For habilitation services, the State includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funder under §110 of the Rehabilitation Act of 1973.

§1915(i) Home and Community Based Services (HCBS) State Plan Services
NUMBER SERVED

- 1. Projected Number of Unduplicated Individuals To Be Served Annually.** The first year projection is based on current utilization of all services combined. Growth in succeeding years is projected at 6.5%, which reflects the average annual caseload growth rates experienced by DHCFP.

Annual Period	From	To	Projected Number of Participants
Year 1	7/1/2007	6/30/2008	4655
Year 2	7/1/2008	6/30/2009	4958
Year 3	7/1/2009	6/30/2010	5280
Year 4	7/1/2010	6/30/2011	5623
Year 5	7/1/2011	6/30/2012	5989

§1915(i) Home and Community Based Services (HCBS) State Plan Services
NUMBER SERVED

2. **Optional Annual Limit on Number Served.:**

- The State does not limit the number of individuals served during the Year.
- The State chooses to limit the number of individuals served during the Year.:

Annual Period	From	To	Annual Maximum Number of Participants
Year 1			
Year 2			
Year 3			
Year 4			
Year 5			

- The State chooses to further schedule limits within the above annual period(s).:

§1915(i) Home and Community Based Services (HCBS) State Plan Services
NUMBER SERVED

3. **Waiting List.**

- The State will not maintain a waiting list.
- The State will maintain a single list for entrance to the HCBS state plan supplemental benefit package. State-established selection policies: are based on objective criteria; meet requirements of the Americans with Disabilities Act and all Medicaid regulations; ensure that otherwise eligible individuals have comparable access to all services offered in the package.

§1915(i) Home and Community Based Services (HCBS) State Plan Services
FINANCIAL ELIGIBILITY

1. **Income Limits.** The State assures that individuals receiving state plan HCBS are in an eligibility group covered under the State's Medicaid state plan, and who have income that does not exceed 150% of the Federal Poverty Level (FPL).

§1915(i) Home and Community Based Services (HCBS) State Plan Services
FINANCIAL ELIGIBILITY

2. Medically Needy.:

- The State does not provide HCBS state plan services to the medically needy.
- The State provides HCBS state plan services to the medically needy:
 - The State elects to waive the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy.
 - The State does not elect to waive the requirements at section 1902(a)(10)(C)(i)(III).

§1915(i) Home and Community Based Services (HCBS) State Plan Services
NEEDS-BASED EVALUATION/REEVALUATION

1. **Responsibility for Performing Evaluations / Reevaluations.** Independent evaluations / reevaluations to determine whether applicants are eligible for HCBS are performed:

Directly by the Medicaid agency

By Other: QIO-like agency

§1915(i) Home and Community Based Services (HCBS) State Plan Services
NEEDS-BASED EVALUATION/REEVALUATION

- 2. Qualifications of Individuals Performing Evaluation/Reevaluation.** There are qualifications (that are reasonably related to performing evaluations) for persons responsible for evaluation/reevaluation for eligibility.:
1. The QIO-like agency employs licensed registered nurses and licensed social workers to evaluate/re-evaluate for eligibility.
 2. All the individuals performing evaluations/reevaluations will have professional credentials and experience in evaluating an individual's needs for medical and social supports.

§1915(i) Home and Community Based Services (HCBS) State Plan Services

NEEDS-BASED EVALUATION/REEVALUATION

3. **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

Prior authorization must be obtained through the QIO-like vendor using universal needs assessment tool. This same process is used to both evaluate and reevaluate whether an individual is eligible for the 1915(i) services.

§1915(i) Home and Community Based Services (HCBS) State Plan Services
NEEDS-BASED EVALUATION/REEVALUATION

4. **Needs-based HCBS Eligibility Criteria.** Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for HCBS state plan services. The criteria take into account the individual's support needs and capabilities and may take into account the individual's ability to perform two or more ADLs, the need for assistance, and other risk factors:

The "1915(i) Home and Community Based Services Universal Needs Assessment Tool" will be used to evaluate and reevaluate whether an individual is eligible for the Nevada 1915(i) HCBS state plan services. In order to qualify for services, the individual meets at least two of the following:

1. the inability to perform 2 or more ADLs;
2. the need for significant assistance to perform ADLs;
3. risk of harm;
4. the need for supervision;
5. functional deficits secondary to cognitive and /or behavioral impairments.

§1915(i) Home and Community Based Services (HCBS) State Plan Services
NEEDS-BASED EVALUATION/REEVALUATION

5. **Needs-based Institutional and Waiver Criteria.** There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of HCBS state plan services. Individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Include copies of the State's official documentation of the need-based criteria for each of the following):*

- *Applicable Hospital*
- *NF*
- *ICF/MR*

Differences Between Level Of Care Criteria

State Plan HCBS needs-based eligibility criteria	NF (& NF LoC waivers)	ICF/MR (& ICF/MR LoC waivers)	Long Term Care Hospital LoC
Individuals need at least two of the following: Functional Impairment in 1. ADL/IADLs, or 2. Cognitive behavior. Or Risk Factors of 3. Medical 4. Need for Supervision 5. Substance Abuse 6. Multiple Social System Involvement	The individual's condition requires services for three of the following: 1. Medication, 2. Treatments/Special Needs, 3. ADLs, 4. Supervision, 5. IADLs	The individual has a diagnosis of Mental retardation or related condition and requires active treatment due to substantial deficits in three of the following: 1. Mobility, 2. Self-Care, 3. Understanding and Use of Language, 4. Learning, 5. Self Direction, and 6. Capacity for Independent Living	The individual has chronic mental illness and has at least three functional deficits: 1. Imminent risk of self harm, 2. Imminent risk of harm to others, 3. Risk of serious medical complications, 4. Need for 24 hour supervision

To qualify for the NF standard, a recipient must score three points on the NF Level of Care Determination. To qualify for State plan HCBS benefit, the recipient must score at least two points on the Universal Needs Based Assessment.

§1915(i) Home and Community Based Services (HCBS) State Plan Services
NEEDS-BASED EVALUATION/REEVALUATION

6. **Reevaluation Schedule.** The State assures that needs-based reevaluations are conducted at least annually.

§1915(i) Home and Community Based Services (HCBS) State Plan Services
NEEDS-BASED EVALUATION/REEVALUATION

7. **Adjustment Authority.** The State will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

§1915(i) Home and Community Based Services (HCBS) State Plan Services
NEEDS-BASED EVALUATION/REEVALUATION

8. **Residence in home or community.** The State plan HCBS benefit will be furnished to individuals who reside in their home or in the community, not an institution. *(Specify any residential settings, other than an individual's home or apartment, in which residents will be furnished State plan HCBS, if applicable. Describe the criteria by which the State determines that these settings are not institutional in character such as privacy and unscheduled access to food, activities, visitors, and community pursuits outside the facility):*

§1915(i) Home and Community Based Services (HCBS) State Plan Services
PERSON-CENTERED PLANNING & SERVICE DELIVERY

1. The State assures that there is an independent assessment of individuals determined to be eligible for HCBS. The assessment is based on:
- An objective face-to-face evaluation by an independent agent trained in assessment of need for home and community-based services and supports;
 - Consultation with the individual and others as appropriate;
 - An examination of the individual's relevant history, medical records, care and support needs, and preferences;
 - Objective evaluation of the inability to perform, or need for significant assistance to perform 2 or more ADLs (as defined in §7702B(c)(2)(B) of the Internal Revenue Code of 1986);
 - Where applicable, an evaluation of the support needs of the individual (or the individual's representative) to participant-direct; and
 - A determination of need for at least one State plan home and community-based service before an individual is enrolled in the State plan HCBS benefit.

§1915(i) Home and Community Based Services (HCBS) State Plan Services

PERSON-CENTERED PLANNING & SERVICE DELIVERY

2. The State assures that, based on the independent assessment, the individualized plan of care:
- Is developed by a person-centered process in consultation with the individual, the individual's: treating physician, health care or supporting professional, or other appropriate individuals, as defined by the State, and where appropriate the individual's family, caregiver, or representative;
 - Identifies the necessary HCBS to be furnished to the individual;
 - Takes into account the extent of, and need for, any family or other supports for the individual;
 - Prevents the provision of unnecessary or inappropriate care;
 - Is guided by best practices and research on effective strategies for improved health and quality of life outcomes; and
 - Is reviewed at least annually and as needed when there is significant change in the individual's circumstances.

§1915(i) Home and Community Based Services (HCBS) State Plan Services
PERSON-CENTERED PLANNING & SERVICE DELIVERY

3. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.** There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with physical and mental needs for HCBS.:

A physician or other licensed practitioner of the healing arts within the scope of this professional practice as defined and limited by Federal and State law with experience in conducting assessments will be responsible for conducting the face-to-face independent assessments and reassessments of an individual's support needs and capabilities.

§1915(i) Home and Community Based Services (HCBS) State Plan Services
PERSON-CENTERED PLANNING & SERVICE DELIVERY

4. **Responsibility for Service Plan Development.** There are qualifications (that are reasonably related to developing plans of care) for persons responsible for the development of the individualized, person-centered plan of care.

The service plan is developed by the service provider. An interdisciplinary team will formulate the plan in conjunction with the recipient. The team must include staff trained in person-centered planning, and must include a licensed health care professional and may include other individuals who can contribute to the plan development. Recipient and family involvement in service planning must be documented in the Service Plan.

The Conflict of Interest Standards specified in Administration and Operation, question #5 are applicable to service plan development.

§1915(i) Home and Community Based Services (HCBS) State Plan Services
PERSON-CENTERED PLANNING & SERVICE DELIVERY

5. **Supporting the Participant in Service Plan Development.** Supports and information are made available to the participant (and/or the additional parties specified, at the choice of the participant) to direct and be actively engaged in the service plan development process.:

Participants are provided by the service case manager or the DHCFP District Office staff with information about the person-centered planning process, their opportunity to select who participates in the planning, the services available and the available providers.

The provider will ensure the recipient, or the recipient's legal representative, is fully involved in the treatment planning process and choice of providers. The provider will also ensure the participant has an understanding of the needed services and the elements of the Service Plan. Participant's, family's (at the choice of the participant) and/or legal representative's participation in treatment planning must be documented on the Service Plan.

Providers will ensure the recipient or the recipient's legal representative is fully involved in the plan of care and ongoing day to day delivery of services, while promoting the rights of the client in regards to choice of services and providers.

§1915(i) Home and Community Based Services (HCBS) State Plan Services
PERSON-CENTERED PLANNING & SERVICE DELIVERY

6. Informed Choice of Providers:

A physician or other licensed practitioner of the healing arts conducts the needs-based assessment and refers the recipient to the local Medicaid District Office for a list of providers who meet Medicaid requirements and have a Medicaid contract to provide needed services. The Medicaid District Office will provide information and assistance in contacting Medicaid providers, including a list of providers and service descriptions. The recipient or the recipient's representative contacts the provider to select a provider of services. The provider of services is responsible for obtaining a written statement that the recipient was offered a choice of providers.

§1915(i) Home and Community Based Services (HCBS) State Plan Services
PERSON-CENTERED PLANNING & SERVICE DELIVERY

7. Process for Making Service Plan Subject to the Approval of the Medicaid Agency:

The quality improvement organization (QIO) selected by Nevada Medicaid will approve all service plans. Additionally, DHCFP staff or designee will review a representative sample of participant service plans each year, with a confidence level of 95%.

§1915(i) Home and Community Based Services (HCBS) State Plan Services
PERSON-CENTERED PLANNING & SERVICE DELIVERY

8. **Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of three years as required by 45 CFR §74.53. Service plans are maintained by the following:

- Medicaid agency
- Case Manager
- Other: Service providers

§1915(i) Home and Community Based Services (HCBS) State Plan Services
SERVICES

1. Home and Community Based Services (HCBS) State Plan Services:

Service Specifications

Service Title: Home and Community Based (HCBS) Adult Day Health Care:

Service Definition (Scope): Adult Day Health Care services include health and social services needed to ensure the optimal functioning of the participant. Services are generally furnished in four or more hours per day on a regularly scheduled basis. The schedule may be modified as specified in the service plan (not to exceed 6 hours per day). Services must take place in a non-institutional or community-based setting.

Services provided by the appropriate professional staff include the following:

- Care coordination
- Supervision and assistance to the recipient, to ensure the recipient's well being and that care is appropriate to recipient's needs
- Nursing Services
 - Assessment
 - Care planning
 - Treatment
 - Medication administration
- Restorative therapy and care
- Nutritional assessment and planning
- Recipient training in activities of daily living
- Social activities to ensure the recipient's optimal functioning
- Meals (*Meals provided as a part of these services shall not constitute a "full nutritional regimen" (3 meals per day).*)

§1915(i) Home and Community Based Services (HCBS) State Plan Services
SERVICES

Specify limits (if any) on the amount, duration, or scope of this service for:

- Categorically needy: No more than 6 hours per day per recipient.
- Medically needy:

Specify whether the service may be provided by a: Relative
 Legal Guardian
 Legally Responsible Person

Provider Qualifications:

Provider Type:	License:	Certification:	Other Standard:
Home and Community Based Services (HCBS) Adult Day Health Care Facility	Licensed by the Health Division Bureau of Licensure and Certification, as an Adult Day Care Facility	Certified by the Division of Health Care Financing and Policy as an Adult Day Health Care provider that provides medical/nursing services in conjunction with adult day care activities.	Must maintain a Medicaid Services Provider Agreement and comply with the criteria set forth in the Medicaid Services Manual.

Verification of Provider Qualifications:

Provider Type:	Entity Responsible for Verification:	Frequency of Verification:
Home and Community Based Services (HCBS) Adult Day Health Care Facility	Division of Health Care Financing and Policy (DHCFP)	Annual

Service Delivery Method:

- Participant-directed
- Provider managed

FIN REF: Attachment 4.19-B, Page 15 – 15b

§1915(i) Home and Community Based Services (HCBS) State Plan Services
SERVICES

Service Title: Habilitation

Service Definition (Scope): Habilitation Services include services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. Habilitation Services are prescribed by a physician, provided by the appropriate qualified staff, and include the following:

- Care Coordination
- Adaptive Skill Development
- Assistance with Activities of Daily Living
- Community Inclusion
- Transportation (not duplicative of State Plan non-emergency transportation)
- Adult Educational Supports
- Social and Leisure Skill Development
- Physical Therapy
- Speech Therapy
- Occupational Therapy

Habilitation services under Section 1915(i) do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 (IDEA), which otherwise are available to the individual through a local education agency, and vocational rehabilitation services, which otherwise are available to the individual through a program funded under Section 110 of the Rehabilitation Act of 1973. Documentation to this effect will be maintained in the file of each individual receiving habilitation services that may be duplicated through these specific authorities.

The professional provider must see a patient at least once, have some input as to the type of care provided, review the patient after treatment has begun, and assume legal responsibility for the services provided.

§1915(i) Home and Community Based Services (HCBS) State Plan Services
SERVICES

Additional needs-based criteria for receiving the service, if applicable:

Recipient must need Habilitation services as identified in the functional assessment as assessed by a Licensed Practitioner of the Healing Arts within the scope of professional practice as defined and limited by Federal and State law.

Specify limits (if any) on the amount, duration, or scope of this service for:

- Categorically needy: Each service is subject to Utilization Management.
- Medically needy:

Specify whether the service may be provided by a:

- Relative
- Legal Guardian
- Legally Responsible Person

Provider Qualifications:

Provider Type	License	Certification	Other Standard
Habilitation Services Provider Agency	No state license required for the agency.	Current accreditation with either the Commission on Accreditation of Rehabilitation Facilities or the Joint Commission on the Accreditation of Health Organizations.	Must maintain a Medicaid Services Provider Agreement and comply with criteria specified in the Medicaid Services Manual.
Care Coordinator	Must have current licensure as a Social Worker or Registered Nurse as defined in 42CFR440.60.		
Certified Care Coordinator	Must have current licensure as a Social Worker or Registered Nurse as defined in 42CFR440.60.	Current certification.	
Other Licensed Individual who provides Care coordination	Must have current licensure as a Social Worker or Registered Nurse as defined in 42CFR440.60.		Must be a licensed individual that is eligible to apply for certification as a care coordinator or who is working under the direct supervision of a Certificate of Clinical Competence (CCC).
Physical Therapist/ Occupational Therapist/ Speech Therapist	Must have current professional licensure as defined in 42CFR440.110.		

FIN REF: Attachment 4.19-B, Page 16 – 16a

TN#: 07-003
Supersedes
TN#: NEW

Approval Date OCT 3 1 2008 Effective Date: November 1, 2008

§1915(i) Home and Community Based Services (HCBS) State Plan Services
SERVICES

Registered Nurse	Must have current licensure as a Registered Nurse as defined in 42CFR440.60.	Registered Nurse	Must have current licensure as a Registered Nurse as defined in 42CFR440.60.
Physician	Must have current licensure as a Physician as defined in the 42CFR440.50.		
Habilitation Technician			<p>Possess high school diploma or GED; some post-secondary educational experience preferred; a minimum of two positive, verifiable employment experiences; two years of related experience; job experience that demonstrates the ability to teach, work independently of constant supervision, demonstrate regard and respect for recipients; have verbal and written communication skills; the ability to multi-task; the ability to follow through with designated tasks; knowledge of the philosophy and principles of independent living for people with disabilities.</p> <p>Habilitation Technicians must be directly supervised by a licensed/certified Therapy provider as defined in 42CFR440.110. Documentation will be kept supporting the supervision of service and ongoing involvement in the treatment by the supervising qualified provider.</p>
Licensed Psychologist	Must have current licensure as a Psychologist as defined in 42CFR440.60.		

Verification of Provider Qualifications:

Provider Type:	Entity Responsible for Verification:	Frequency of Verification:
Habilitation Services Provider Agency	The designated QIO like-vendor for Nevada Medicaid.	Annual

Service Delivery Method:

- Participant-directed
- Provider managed

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§1915(i) Home and Community Based Services (HCBS) State Plan Services
SERVICES

**Service Title: Home and Community Based Services (HCBS) Day Treatment or Other
Partial Hospitalization Services for Individuals with Chronic Mental Illness**

Service Definition (Scope): Partial Hospitalization Services for Individuals with Chronic Mental Illness is a comprehensive interdisciplinary program aimed at supporting individuals with chronic mental illness and substance related disorders that require assistance with the acquisition, retention, or improvement of skills related to living in home and community based settings. The services are furnished under a medical model by a hospital or in an outpatient hospital setting. The service helps recipients with chronic mental illnesses reside in the most normative and least restrictive, family centered environment, and integrated setting appropriate to their medical needs. The goal is to divert recipients from institutional settings to home and community based settings.

Services include:

- Day treatment,
- Partial hospitalization,
- Intensive Outpatient,
- Medication management,
- Medication management training and support,
- Crisis intervention,
- Screening, assessments, and diagnosis,
- Care coordination,
- Family, group, and individual therapy,
- Psychosocial rehabilitation,
- Communications skills,
- Occupational therapy, and
- Basic skills training:
 - maintenance of the home and community living environment,
 - restoration and maintenance of activities of daily living,
 - community integration and adaptation skills training and development, and
- Therapeutic social and leisure skills training and development.

The service must be prescribed by a physician or other licensed practitioner of the healing arts within the scope of this professional practice as defined and limited by Federal and State law.

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§1915(i) Home and Community Based Services (HCBS) State Plan Services
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Additional needs-based criteria for receiving the service, if applicable:

Partial Hospitalization Services for Individuals with Chronic Mental Illness are based on an intensity of needs determination and are aimed at supporting recipients who need the amount, duration, and scope of medical assistance to:

- improve or retain functioning,
- prevent relapse,
- assistance with self care and treatment,
- assistance with family inclusion and integration,
- assistance with activities of daily living,
- assistance with medication education and training,
- assistance with educational supports,
- home and community living environment skills,
- community integration and adaptation skills, and
- therapeutic social and leisure skills.

Specify limits (if any) on the amount, duration, or scope of this service for:

- Categorically needy: Each service is subject to Utilization Management.
- Medically needy:

Specify whether the service may be provided by a:

- Relative
- Legal Guardian
- Legally Responsible Person

§1915(i) Home and Community Based Services (HCBS) State Plan Services
SERVICES

Provider Qualifications:

Provider Type:	License:	Certification:	Other Standard:
Qualified Mental Health Provider	<ul style="list-style-type: none"> ▪ Licensed Physician 42CFR440.50 ▪ Licensed Psychiatrist 42CFR440.50 ▪ Licensed Psychologist 42CFR440.60 ▪ Licensed Registered Nurse 42CFR440.60 ▪ Licensed Advanced Practitioner of Nursing 42CFR440.60 ▪ Licensed Nurse Practitioner 42CFR440.60 ▪ Licensed Marriage and Family Therapist 442CFR440.60 ▪ Licensed Clinical Social Worker 42CFR440.60 ▪ Licensed Interns under the direction of the above categories 42CFR440.60 	Graduate degrees appropriate for licensure	Mental Health Counselor employed by State Mental Health Authority

Verification of Provider Qualifications:

Provider Type:	Entity Responsible for Verification:	Frequency of Verification:
QMHP	Division of Health Care Financing and Policy	Annual

Service Delivery Method:

- Participant-directed
- Provider managed

§1915(i) Home and Community Based Services (HCBS) State Plan Services
SERVICES

2. Policies Concerning Payment for State Plan Home and Community Based Services (HCBS) Furnished by Legally Responsible Individuals, Other Relatives and Legal Guardians:

- The State does not make payment to legally responsible individuals, other relatives or legal guardians for furnishing state plan Home and Community Based Services (HCBS).

- The State makes payment to:
 - Legally Responsible Individuals.** The State makes payment to legally responsible individuals under specific circumstances and only when the relative is qualified to furnish services:
 - Relatives.** The State makes payment to relatives under specific circumstances and only when the relative is qualified to furnish services:
 - Legal Guardians.** The State makes payment to legal guardians under specific circumstances and only when the guardian is qualified to furnish services:
 - Other policy.:**

§1915(i) Home and Community Based Services (HCBS) State Plan Services
SERVICES

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. Election of Participant-Direction.:

- The State does not offer opportunity for participant-direction of state plan Home and community Based Services (HCBS).
- Every participant in HCBS state plan services (or the participant's representative) are afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
- Participants in HCBS state plan services (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the State.

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2. Description of Participant-Direction.:

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3. Participant-Directed Services:

Participant-Directed Service	Employer Authority	Budget Authority
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

§1915(i) Home and Community Based Services (HCBS) State Plan Services
SERVICES

4. Financial Management:

- Financial Management is not furnished. Standard Medicaid payment mechanisms are used.

- Financial Management is furnished as an administrative function.

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5. **Participant-Directed Service Plan.** The State assures that, based on the independent assessment, a person-centered process produces an individualized plan of care for participant-directed services that:
- Is directed by the individual or authorized representative and builds upon the individual's preferences and capacity to engage in activities that promote community life;
 - Specifies the services to be participant-directed, and the role of family members or others whose participation is sought by the individual or representative;
 - For employer authority, specifies the methods to be used to select, manage, and dismiss providers;
 - For budget authority, specifies the method for determining and adjusting the budget amount, and a procedure to evaluate expenditures; and
 - Includes appropriate risk management techniques.

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6. Voluntary and Involuntary Termination of Participant-Direction:

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7. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can hire and supervise staff).

- The State does not offer opportunity for participant-employer authority.
- Participants may elect participant-employer Authority.
- Participant/Co-Employer.** The participant (or the participant’s representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
- Participant/Common Law Employer.** The participant (or the participant’s representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant’s agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. Participant–Budget Authority (individual directs a budget).

- The State does not offer opportunity for participants to direct a budget.
- Participants may elect Participant–Budget Authority.

Participant-Directed Budget:

Expenditure Safeguards:

§1915(f) Home and Community Based Services (HCBS) State Plan Services
QUALITY MANAGEMENT STRATEGY

Requirement	Monitoring Activity (What)	Monitoring Responsibilities (Who)	Evidence (Data Elements)	Management Reports (Yes/No)	Frequency (Mos/Yrs)
<p>Service plans address assessed needs of enrolled participants, are updated annually, and document choice of services and providers.</p>	<ol style="list-style-type: none"> All person-centered service plans will be reviewed when initially submitted by the provider. A representative sample of service plans for the entire population will be reviewed annually. Participant Experience Survey (PES) data addresses access to care, choice and control, respect/dignity, community integration and inclusion. A needs assessment will be done at least annually for all participants. A representative sample will be reviewed to determine changes in functioning levels within the sample and try to get a picture of the total population. 	<ol style="list-style-type: none"> QIO-like vendor DHCFF DHCFF DHCFF 	<ol style="list-style-type: none"> & 2. Current assessment is in the file. Current service plans exist in the file. Service plan addresses all the assessed needs. Service plan is person-centered. Choice of providers is documented in the case file. Results of PES Results of representative sample review of changes in functioning level. 	<ol style="list-style-type: none"> & 2. Percent of compliance in each component. trends in changes in percent compliance. Serious problem areas defined. Summary reports of PES Summary reports of sample review of changes in functioning level. Sample represents a 95% confidence level. 	<ol style="list-style-type: none"> Ongoing as submitted Annual At least annually or at discharge. Annual
<p>Providers meet required qualifications</p>	<p>Verify 100% providers meet requirements established for each service, such as licensure, accreditation, etc.</p> <p>Verify all providers have a current Medicaid contract.</p>	<p>DHCFF</p>	<p>DHCFF records the documentation of provider meeting qualifications, such as copies of licenses, certifications and Medicaid contracts.</p>	<p>List of all providers, with reports of compliance in each area of qualification, with percentage compliance.</p>	<p>Review 100% of providers per year.</p>
<p>The SMA retains authority and responsibility for program operations and oversight.</p>	<p>DHCFF conducts routine ongoing monitoring of 1915(f) HCBS.</p>	<p>DHCFF</p>	<p>Documentation of monitoring system. Management reports of monitoring results.</p>	<p>Summary reports of quality of HCB Services</p> <p>Documentation of monitoring findings, remediation, analysis of effectiveness of remediation, and</p>	<p>Ongoing.</p>

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QUALITY MANAGEMENT STRATEGY

<p>The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to enrolled participants by qualified providers.</p>	<p>DHCFF oversight exists through the MMS system to assure claims are coded and paid in accordance with the state plan. State Plan HCB Services will be included in the population of paid claims subject to a PERM-like financial review. Additionally, a program review of a representative sample of claims will be conducted annually.</p>	<p>DHCFF</p>	<p>MMS reports, PERM-like review reports. Documentation of sample selection process for program review, monitoring tools, monitoring findings reports and management reports.</p>	<p>documentation of system improvement Documentation of monitoring findings, remediation, analysis of effectiveness of remediation, documentation of system improvement.</p>	<p>Ongoing payment edits Annual reviews</p>
<p>The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.</p>	<p>Service plans address health and welfare and are monitored by DHCFF and the QIO-like vendor. Recipients may participate in Participant Experience Surveys (PES) that address access to care, choice and control, respect/dignity and community integration and inclusion. Providers of all services are required to ensure compliance with 42CFR483.374 to assure the health and welfare of recipients with regard to seclusion and restraints.</p>	<p>DHCFF, QIO-like vendor, Bureau of Licensure and Certification (BLC) when appropriate.</p>	<p>DHCFF and QIO-like vendor Program review reports, PES Responses. Complaints received by DHCFF, BLC or incidents identified in program reviews.</p>	<p>Summary reports of BLC tracking results, program reviews and PES.</p>	<p>Ongoing</p>

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QUALITY MANAGEMENT STRATEGY

Describe the process(es) for remediation and systems improvement.

Serious occurrence reports, Participant Experience Surveys and program review reports that identify issues related to a specific participant will be referred to the District Office case manager to assess and remediate immediately, if appropriate. Central Office program specialists will analyze all review findings, prepare reports as indicated above, make recommendations for remediation and submit to a management team or program chief. The report will include an executive summary that highlights important issues that require attention and remediation. Providers will be informed and educated when problems are identified. When necessary a plan of improvement will be required of specific providers that do not meet standards specified in the Medicaid Services Manual. If corrective action is determined by DHCFP to not be adequate, appropriate actions will be taken and may include temporary suspension or full termination of provider Medicaid contracts. Program specialists will assess the effectiveness of remediations and report results to the management team or program chief. The Management Team or Program Chief will review and approve the report or return to the program specialist for additional information or action. When complete the program specialist and the management team or Program Chief will determine whether the monitoring system has been effective or needs improvement.

The State plans to treat remediation and improvement activities for delegated functions by a similar methodology to the process described above. Once any issue is identified through management procedures or reports related to claims utilization, level of care determinations, notices of decision, fair hearing outcomes, audit findings, or utilization management trends, DHCFP works directly with the responsible delegated entity to remediate the findings and prioritize in its systems improvement processes. DHCFP is in the process of developing a meaningful statewide monitoring, analysis and remediation system for these occurrences. DHCFP will assess how best to distinguish and prioritize incident reports to identify trends and work with affected entities to effectively prioritize based on the impact to the recipient and the needs of all parties involved.

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Attachment 4.19

ASSURANCES

All general rates described in Attachment 4.19 may be accessed at:

<http://dhcjp.nv.gov/RatesUnit.htm>

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1915(i) Home and Community Based Services (HCBS) State Plan Services
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate:

HCBS Care Coordination

1915(i) Home and Community Based Services (HCBS) State Plan Services
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

- HCBS Homemaker
 - HCBS Basic Homemaker
 - HCBS Chore Services

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

HCBS Home Health Aide

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

HCBS Personal Care

- HCBS Personal Care I
- HCBS Personal Care II
- HCBS Attendant Services
- HCBS Adult Companion
- HCBS Personal Emergency Response Systems
- HCBS Assistive Technology

1915(i) Home and Community Based Services (HCBS) State Plan Services
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Home and Community Based Services (HCBS) Adult Day Health

Adult Day Health Care (ADHC) rate methodology was based on the Provider Rates Task Force, September 15, 2002. Final Strategic Plan, rate calculation for Adult Day Care - Medical Model.

The billable unit of service for Adult Day Health is 1 unit per 15 minutes.

Rate Methodology:

The rate is market based. This model is developed to reflect service definitions, provider requirements, operational service delivery and administrative considerations. The following elements are used to determine the rate:

- Wage information is taken from the Bureau of Labor Statistics (BLS). The wage is based on similar occupations reported by BLS and identified by Medicaid staff as comparable to ADHC services.
- Employee related expenses (ERE) percentage of 27% was based on input from the Task Force members and Medicaid Staff. It includes paid vacation, paid sick leave, holiday pay, health insurance, life insurance, disability, workers compensation, and legally required payroll taxes.
- Productivity adjustment factor which accounts for the amount of non-billable time spent by staff. This includes the time staff needs to complete required documentation and record keeping, time associated with missed appointments and average travel time by the provider.
- Administrative overhead, 10%, is the percentage of service cost that should result from non-direct care activities. It includes insurance, administrative staff, operations and management activities and office supplies. Capital and related expenses is not included. It also does not include staff training.
- Allowances for capital costs – the costs are not included in the Administrative overhead. It includes the average hourly expense for building rental and maintenance, equipment leasing and utility expenses.

The following steps are used to determine the rate:

1. The State will use Nevada-specific hourly wages from the Bureau of Labor Statistics as of May, 2004 inflated to June, 2006.
2. This hourly compensation is increased by the 27% ERE.
3. A productivity factor is applied to the hourly compensation calculated in Item 2 to equal to the adjusted hourly rate.
4. Administrative overhead (10%) is applied to the adjusted hourly rate (Item 3).
5. Determine allowance for capital costs per hour.
6. Fixed hourly rate is the sum of adjusted hourly rate (Item 3), administrative overhead (Item 4) and capital costs (Item 5).

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

7. Fixed hourly rate is scaled to the proper unit based on the procedure code.

This rate has been compared to other private sector fee-for-service rates. Documentation of the assumptions used, rate development methodology, and fee schedule payment rates will be maintained by The Division of Health Care Financing and Policy.

The agency's rates were set as of January 1, 2006 and are effective for services on or after January 1, 2006. All rates are published on the agency's website at: <http://dhcfnv.gov>.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Services provided by an out-of-state provider require prior authorization by Nevada Medicaid, which must verify that the services required by Medicaid-eligible or pending-eligible clients are not available in Nevada. The out-of-state payment rate for services provided by an out-of-state provider is based on one of the following criteria:

- A. The out-of-state provider will be paid the lesser of the provider's billed charges or the fee-for-service rate that is paid to an in-state provider for the service.
- B. If the out-of-state provider refuses to accept this rate, then the out-of-state provider may be paid the lesser of the provider's billed charges or the same fee-for-service rate as it would be paid by its home state Medicaid program.
- C. For services that cannot be provided by a provider that accepts payment under (A) or (B), the State will maintain a list of other qualified out-of-state providers, and will negotiate competitive rates that will not exceed the provider's customary charge.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Habilitation

Home and Community Based Services (HCBS) Home-Based Habilitation

The billable units of service for Home-Based Habilitation Services are:

- Half Day Medical Rehab – 1 unit is 3 hrs
- Full Day Medical Rehab – 1 unit is 6 hrs
- Residential Medical Rehab – 1 unit is 24 hours
- Community/work integration training – 1 unit per 15 mins

The Home-Based Habilitation Services are reimbursed the lower of a) billed charges for b) fee schedule rates of:

- Half Day Medical Rehab - \$220.38/unit
- Full Day Medical Rehab - \$440.75/unit
- Residential Medical Rehab - \$651.00/per diem
- Community/work integration training - \$5.38/unit

The fee schedule rates for the billing units of the Home-Based Habilitation services are developed based on the following components:

- Wage information – except for physician, wage information is based on reports from the Bureau of Labor Statistics (BLS) and identified by Medicaid staff as comparable to Home-Based Habilitation services. The healthcare professionals for home-based habilitation services include:
 - Case Managers
 - Therapists (PT/OT/ST)
 - Registered Nurses
 - Rehab Technicians
 - Psychologists
- Physician Contract Costs – estimate of hourly cost of contracted physician is based on BLS reports for gross salary of primary care physicians, grossed up to reflect ratio of practice revenue to pre-tax salary equivalent.
- Employee related expenses (ERE) percentage of 27% includes employee benefits such as life insurance, medical insurance, employee education benefits, etc. and statutory employer contributions such as social security, unemployment insurance, workers compensation and Medicare.
- Other costs and economy factor: Approximately 35% of total business costs relate to non-direct care activities. Non-direct care activities include facility rent/lease, purchased services, accounting, legal, utilities, supplies, postage, copying, administrative/business travel, insurance,

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

fidelity bond, etc. The economy factor, approximately 15%, represents an additional premium in addition to direct and other costs to attract willing and qualified service providers.

The following steps are used to form a reasonable basis to determine the average fee schedule rates:

1. The State will use the hourly wage information of each healthcare professional, from the BLS and the contract rate estimate for physicians.
2. The hourly compensation for each professional is allocated to each billable service unit, i.e. half day, full day and 24 hours residential, based on the average proportion of the time each healthcare professional provided for each billable service unit.
3. The aggregate amount of each individual professional's allocated compensation by billable service unit (Item 2) is increased by 27% of ERE to equal to direct care costs by each billable service unit.
4. Other costs and economy factor are applied to the direct care costs by each billable service unit (Item 3) to equal the estimated amount of all other costs and economy factor by each billable unit.
5. The sum of direct care costs (Item 3) and other costs and economy factor (Item 4) of all the billable services is adjusted to account for the impact of utilization patterns to arrive at the fee schedule rate for each of the billable services. The utilization of each billable service unit is:
 - Half Day Medical Rehab - 5%
 - Full Day Medical Rehab - 50%
 - 24 hour Residential - 45%

The agency's rates were set as of January 1, 2006 and are effective for services on or after January 1, 2006. All rates are published on the agency's website at: <http://dhcfp.nv.gov>.

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1915(i) Home and Community Based Services (HCBS) State Plan Services
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

For Individuals with Chronic Mental Illness, the following services provided by a government entity:

- Home and Community Based Services (HCBS) Day Treatment or Other Partial Hospitalization Services for Individuals with Chronic Mental Illness

Partial Hospitalization - 1 unit per 60 mins
Intensive Outpatient Program - per Diem

Rate Methodology:

HCBS Day Treatment or Other Partial Hospitalization services provided by a state or local government entity for individuals with chronic mental illness are reimbursed according to a methodology used to certify costs as representing expenditures eligible for FFP and may be used only by providers who undergo all Medicaid cost identification, reporting, reconciliation and settlement procedures.

I. the lower of: a) billed charges; or b) an interim rate. The Interim rate is the rate for a specific service for a period that is provisional in nature, pending the completion of cost reconciliation and a cost settlement for that period.

To determine the Medicaid-allowable direct and indirect costs of providing HCBS Day Treatment or Other Partial Hospitalization services the following steps are performed:

1. Interim Rates

Governmental providers are reimbursed on an interim basis for direct medical services per unit of service at the lesser of the provider's billed charges or a provider-specific interim rate. A provider-specific interim rate is an annual rate for the specific services for a period that is provisional in nature, pending the completion of cost reconciliation and a cost settlement for that period. Interim rates are based on program experience and cost data reported during the prior fiscal year.

2. Annual Cost Report Process

Each governmental provider will complete an annual cost report in the format proscribed by Nevada Medicaid in the Medicaid Operations Manual for all medical services delivered during the previous state fiscal year covering July 1 through June 30. The cost report is due on or before December 1 of the year following the close of the reporting period. The primary purposes of the cost report are to:

- a. document the provider's total Medicaid-allowable cost for delivering the medical services, including direct costs and indirect costs, based on the methodologies/steps described below; and
- b. reconcile its interim payments to its total Medicaid-allowable costs.

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1915(i) Home and Community Based Services (HCBS) State Plan Services

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

The methodologies/steps are incorporated in the approved Cost Allocation Plan (PACAP) to facilitate the accumulation of Medicaid allocable and allowable cost.

The annual Medicaid Cost Report includes a certification of the provider's actual, incurred allocable and allowable Medicaid costs/expenditures. All filed annual Cost Reports are subject to audit by DCHFP or its designee.

To determine the Medicaid-allowable direct and indirect costs of providing covered services to Medicaid-eligible clients, the following steps are performed:

A. Facilities that are primarily providing medical services

- (a) Direct costs for covered services include unallocated payroll costs and other unallocated costs that can be directly charged to covered medical services. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct care staff. Other direct costs include costs directly related to the delivery of covered services, such as supervision, materials and supplies, professional and contracted services, capital outlay, and travel. These costs must be in compliance with Medicaid non-institutional reimbursement policy and are accumulated on the annual cost report, resulting in total direct costs.
- (b) The direct costs from Item (a) are reduced by any amount that is not in compliance with Medicaid non-institutional reimbursement policy and are further reduced by any federal payments for those costs resulting in adjusted direct costs for covered services.
- (c) Indirect costs are determined by either applying the agency specific approved indirect cost rate to its net direct costs. If the provider has no approved indirect cost rate, the allocated indirect costs can be derived from the allocation process through the provider's approved cost allocation plan. These allocated indirect costs are reduced by any unallowable amount based on Medicaid non-institutional reimbursement policy. The indirect costs details are accumulated on the annual cost report.
- (d) Net direct costs (Item b) and indirect costs (Item c) are combined.
- (e) A CMS approved time study is required when providers of service do not spend 100% of their time providing the Medical services described in the applicable section 3.1-A State plan pages and is used to determine the percentage of time that medical service personnel spend on direct medical services, general and administrative time, and all other activities to account for 100 percent of the time to assure that there is no duplicate claiming. This CMS approved time study methodology will be used to separate

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

administrative activities and direct services. The direct medical services time study percentage is applied against the net direct and indirect costs.

- (f) Medicaid's portion of total allowable costs is calculated by multiplying the result from Item (e) above to the ratio of the total units of service provided to Medicaid eligible clients to the total units of service provided.
 - (g) Total Medicaid allowable costs (Item f) is reduced by any revenue, e.g. Medicaid co-payments and TPL, received for the same service to arrive at the total Medicaid net allocable and allowable costs.
- B. Facilities that are used for multiple purposes, and the provision of medical services is not the primary purpose**
- (a) Direct costs include unallocated payroll costs and medical equipment and supplies. Unallocated payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct care staff. These costs are accumulated on the annual cost report.
 - (b) The Direct costs from Item (a) are reduced by any amount that is not in compliance with Medicaid non-institutional reimbursement policy and are further reduced by any federal payments for those costs, resulting in adjusted direct costs.
 - (c) Indirect costs are determined by applying the agency specific approved indirect cost rate to its net direct costs (Item b.). If the entity has no approved indirect costs rate, the allocated indirect costs can be derived from the allocation process through the provider's approved cost allocation plan.
- These indirect costs are reduced by any unallowable amount. For these facilities, allowable costs are only those costs that are "directly attributable" to the professional component of providing the medical services and are in compliance with Medicaid non-institutional reimbursement policy. For those costs incurred that "benefit" multiple purposes but would be incurred at the same level if the medical services did not occur are not allowed, e.g. room and board, allocated cost from other related organizations. The indirect cost details are accumulated on the annual cost report.
- (d) Net direct costs (Item (b)) and indirect costs (Item (c)) are combined.

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- (e) A CMS approved time study is required when providers of service do not spend 100% of their time providing the medical services described in the applicable section 3.1-A State plan pages and is used to determine the percentage of time that medical service personnel spend on direct medical services, general and administrative time, and all other activities to account for 100 percent of the time to assure that there is no duplicate claiming. This time study methodology will be used to separate administrative activities and direct services. The direct medical services CMS approved time study percentage is applied against the net direct and indirect costs.
- (f) Medicaid's portion of the total net allocable and allowable costs is calculated by multiplying the result from Item (e) above to the ratio of total units of service provided to Medicaid eligible clients to the total units of service provided.
- (g) Total Medicaid allowable costs (Item f) is reduced by any revenue received for the same services, e.g. Medicaid co-payments and TPL, to arrive at the total Medicaid net allocable and allowable costs.

3. Cost Reconciliation Process

Governmental providers will be responsible for reconciling total allowable computable costs reported on the cost report to the provider's Medicaid interim payments for Medicaid services delivered during the reporting period as document in the MMIS, resulting in cost reconciliation. The cost reconciliation process must be completed within twenty-four months of the end of the reporting period covered by the annual Cost Report.

4. Cost Settlement Process

If a governmental provider's interim payments exceed the actual, certified costs of the provider for services to Medicaid clients, DHCFP will recoup the federal share of the overpayment using one of the following two methods:

1. Off-set all future claims payments from the provider until the amount of the federal share of the overpayment is recovered;
2. The provider will return an amount equal to the overpayment.

If the actual, certified costs exceed the interim Medicaid payments, DHCFP will pay the federal share of the difference to the provider in accordance with the final actual certification agreement.

DHCFP will issue a notice of settlement that denotes the amount due to or from the provider.

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The following steps are used to determine the rates:

1. The State will use Nevada-specific hourly wages from the Bureau of Labor Statistics as of May, 2004 inflated to June, 2006.
2. The hourly amount is increased by the 27% ERE.
3. A productivity factor is applied to the hourly compensation calculated in Item 2 to equal the hourly rate.
4. The hourly rate per individual is the hourly rate (Item 3) divided by the number of individuals based on staffing ratio assumption.
5. The adjusted hourly rate per individual is the hourly rate per individual (Item 4) increased by the program support costs per hour per individual, allowance for supervisory time and capital costs per hours.
6. Administrative overhead 10% is applied to the adjusted hourly rate per individual (Item 5).
7. Total hourly rate is the sum of the adjusted hourly rate per individual before administrative overhead (Item 5) and the administrative overhead (Item 6).
8. Total hourly rate is scaled to the proper unit based on the billable unit of service.

These rates have been compared to other private sector fee-for-service rates. Documentation of the assumptions used, rate development methodology, and fee schedule payment rates will be maintained by The Division of Health Care Financing and Policy.

The agency's rates were set as of January 1, 2006 and are effective for services on or after January 1, 2006. All rates are published on the agency's website at: <http://dhcfp.nv.gov>.

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Services provided by an out-of-state provider require prior authorization by Nevada Medicaid, which must also verify that the services required by Medicaid-eligible or pending eligible clients are not available in Nevada. The out-of-state payment rate for services provided by an out-of-state provider is based on one of the following criteria:

- A. The out-of-state provider will be paid the lesser of the provider's billed charges or the fee-for-service rate that is paid to an in-state provider for the services.
- B. If the out-of-state provider refuses to accept this rate, then the out-of-state provider may be paid the lesser of the provider's billed charges or the same fee-for-service rate as it would be paid by its home state Medicaid program.
- C. For services that cannot be provided by a provider that accepts payments under (A) or (B), the State will maintain a list of other qualified out-of-state providers, and will negotiate competitive rates that will not exceed the provider's customary charge.

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1915(i) Home and Community Based Services (HCBS) State Plan Services
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2. Presumptive Eligibility for Assessment and Initial HCBS. Period of presumptive payment for HCBS assessment and initial services, as defined by 1915(i)(1)(J):

- The State does not elect to provide for a period of presumptive payment for individuals that the State has reason to believe may be eligible for HCBS.

- The State elects to provide for a period of presumptive payment for independent evaluation, assessment, and initial HCBS. Presumptive payment is available only for individuals covered by Medicaid that the State has reason to believe may be eligible for HCBS, and only during the period while eligibility for HCBS is being determined. The presumptive period will be 60 days (not to exceed 60 days).

