## Section I - Program Description

*This section should contain information describing the goals and objectives of the Demonstration, as well as the hypotheses that the Demonstration will test. In accordance with 42 CFR 431.412(a)(i), (v) and (vii), the information identified in this section must be included in a state's application in order to be determined complete. Specifically, this section should:*

1) Provide a summary of the proposed Demonstration program, and how it will further the objectives of title XIX and/or title XXI of the Social Security Act (the Act). (This summary will also be posted on Medicaid.gov after the application is submitted. If additional space is needed, please supplement your answer with a Word attachment);

**THE NEED FOR TRANSFORMING OUR SYSTEM**

**The Nevada Department of Health and Human Services (DHHS), Division of Health Care Financing and Policy (DHCFP) as a part of the National Governors Association Policy Academy seeks a Medicaid Section 1115 Demonstration waiver from the U.S. Department of Health and Human Services and the Centers for Medicare and Medicaid Services (CMS) to implement an innovative, cost-effective approach to address the behavioral health issues in Nevada's youth population. The vision is a transformed behavioral health system for Nevada's youth that requires non-traditional services to transition the current crisis-based services to a system of early intervention. This program will not only reduce lifetime healthcare costs of treating a person with a behavioral health disorder by moving from an inpatient, crisis-based model to an early intervention model, but it will also change the trajectory of that person's life. This program will focus on the system of care including services that address the social determinants of a youth's life and assist both the parent and family in successfully integrating into a healthy community. This Demonstration develops a program called REACH, Resources for the Advancement of Child Health. It consists of early evaluation and interventions focusing on program coordination, community integration, parent coaching and positive youth development. Improving Nevada's behavioral health system strengthens families, ensures a better future for Nevada's youth, and ultimately improves the lives of the individuals and families living in our communities.**

**In Nevada, the current youth behavioral health system identifies youth only after they have been unsuccessful in school, had interaction with the criminal justice system, have been hospitalized or diagnosed with an Axis I behavioral health diagnosis. According to the Institute on Mental Health (2005), there is a "window of opportunity" when behavioral health symptoms first appear, typically two to four years before the onset of the disorder and subsequent diagnosis (75% of behavioral**



* Medicaid-eligible includes the CHIP population

**health diagnoses are diagnosed by age 24). Focusing on early intervention provides the opportunity to reduce or stop the trajectory to illness. Nevada's Demonstration will target youth for early intervention services at the point when they are showing signs of being at-risk, but have not yet received a behavioral health diagnosis. In the words of the National Council for Community Behavioral Healthcare, prevention and early intervention need to occur "before costs escalate and the prospects of a happy, healthy life disintegrate."**

**Under our current Medicaid system, the state only provides early intervention services when youth have received a behavioral diagnosis. Under this Demonstration, the state will reach youth before they are diagnosed and provide them with evidenced-based, non-traditional services that have proven to change their trajectory. The potential of this proposal has been recognized throughout Nevada and is supported by the Governor's Office, Nevada Superintendent of Schools and the Commissioner of Insurance.**

## COMPONENTS OF THE PROPOSED TRANSFORMATION

### EARLY BEHAVIORAL HEALTH EVALUATION

**The state is working towards establishing a mandate for all youth to receive an early behavioral health evaluation prior to entering the 7th grade. In year one of the Demonstration, youth entering the 7th grade will receive an early behavioral health evaluation (assessing behavioral health risk, suicide risk, trauma and substance abuse). In years two through five of the Demonstration, youth will be evaluated in the schools at the end of 6th grade to ensure all youth will be evaluated prior to entering the 7th grade. By the end of the five year period, all youth who entered 7th grade in Nevada during the Demonstration period will have participated in and benefitted from this program.**

**In order to establish a mandate that would require all youth to receive the early behavioral health evaluation prior to entering 7th grade. The state will engage the insurance commissioner and the legislature and provide them with information on the early evaluation process and its expected impact on Nevada's youth. Historically, behavioral health and mental health screening and identification have been associated with significant stigma. Mental illness is a serious condition but often the diagnosis, or even suggestion of illness, leads to treatment avoidance and isolation. By requiring screening of all youth, which will be aligned with immunization mandates at entry into 7th grade, Nevada hopes to eliminate the stigma universally associated with behavioral health diagnoses.**



* Medicaid-eligible includes the CHIP population

**Evaluating potentially at-risk youth requires a certain level of skill and training by individuals who are linked to a behavioral health network of care. Nevada proposes to train traditional and non-traditional providers to perform the early behavioral health evaluations using an evidence-based evaluation tool called the Child and Adolescent Needs and Strengths. Evaluations will also be provided in various locations (such as schools, court and government offices, Child and Family Services offices, Family Resource Centers, and health clinics and offices). In addition, one of the goals of the Demonstration is to develop a fully integrated early intervention system. As a result, the providers who conduct the evaluations will need to be integrated into a system of care to ensure that youth will have access to early intervention and other services when necessary. The state envisions the "provider systems" to be an integrated part of the youth's community. Examples of these systems of care will include traditional Federally Qualified Health Centers or non-traditional after school programs.**

**The Child and Adolescent Needs and Strengths (CANS) has been selected as the instrument that will be used to evaluate youth for their risk of behavioral health, suicide, trauma and substance abuse. The decision to use this tool was based on numerous factors including stakeholder input and the ability to modify the tool based on the needs of Nevada's youth. Depending upon the result of their evaluations, youth will be put into one of four categories: (1) no risk, (2) watch and wait, (3) rising risk and (4) at risk. In addition, a predictive algorithm will be utilized based on the data provided from the initial evaluation. The predictive algorithm portends risk in the future and suggests where a youth might be had they not received any services. The steps are as follows:**

- **The "no risk" group requires no further action.**
- **The "watch and wait" group receives a follow-up evaluation six months following the initial evaluation.**
- **The "rising risk" group will be enrolled in the REACH program.**



* Medicaid-eligible includes the CHIP population

- **The "at risk" group includes those youth who are determined to have a behavioral health diagnosis or to be in crisis. The evaluation provider will refer the youth to the appropriate clinical provider unless the youth is in crisis in which case the evaluation provider will engage the state's mobile crisis team.[°]**

**The evaluation provider will receive an evaluation fee for: (1) conducting the early behavioral health evaluation, (2) applying the predictive evaluation, (3) referral to a provider for primary care and/or early intervention services if needed and (4) data entry for tracking purposes. The program would also include a per member per month (PMPM) payment for three months and then an incentive payment to the REACH Coordinator when the youth completes the REACH program. All youth enrolled in the program will receive the entire program package of services. While the state requests guidance on how to design this incentive program and receive federal matching funds for these payments, it is believed to support the efforts of early intervention that the waiver seeks to promote.**

**<u>COMPREHENSIVE ASSESSMENTS LINKING PHYSICAL AND BEHAVIORAL HEALTH</u>**

**In addition to our initiative to provide an early behavioral health evaluation for all youth entering 7th grade, the state is pursuing an initiative to provide comprehensive health assessments for all youth. For example, the state would like to increase Early Periodic Screening Diagnosis and Treatment (EPSDT) screenings and expand these screenings to ensure youth will receive a behavioral health assessment along with their well- child exams. The state is interested in developing an incentive payment program to encourage providers to follow this holistic model of care.**

**<u>EARLY INTERVENTION SERVICES</u>**

**As part of this transformation, Nevada is seeking to identify those youth who are rising risk. Rising risk is defined as youth who have a number of risk factors but who have not yet exhibited clinical or behavioral signs that result in a diagnosis. Medicaid-eligible youth who have received an early behavioral health evaluation and have been determined rising risk would be eligible for the Resources for Early Advancement of Child Health or REACH program. The REACH program includes the following components:**

[°] The mobile crisis team is a well-established system in Nevada and consists of a team of clinical professionals who provide immediate crisis intervention and stabilization services as well as referral and transport to the appropriate level of follow-up care.



* Medicaid-eligible includes the CHIP population

1) **REACH Coordination: provides coordination of the REACH program, provides mentoring, coaching, education and resources to REACH program children/families.**
2) **Community Integration: health literacy, social supports, vocational supports, and recreational supports based on child/family needs in order to maintain or improve level of risk.**
3) **Positive Youth Development: opportunities for youth to build, enhance, and maintain skills, assets, and abilities.**
4) **Parent Coaching: assists with daily life skills and supports achievement of objectives to maintain/reduce risk.**

**Under this Demonstration, the state is seeking the authority to claim federal Medicaid matching funds for the early behavioral health evaluations (including reassessments for the watch and wait group) provided to Medicaid-eligible youth in a variety of locations and provided by both traditional and non-traditional providers. By limiting the early evaluations to a specific Medicaid group and allowing non-traditional providers to administer the early behavioral health evaluation, the state seeks to waive the Comparability under the State Plan as this Demonstration limits this program based upon age/grade in school. The state is also requesting authority under the Demonstration to limit the REACH benefit package to only those Medicaid-eligible youth who have been identified as rising risk based on their screening. In addition, the state is requesting the authority to claim federal matching funds for the REACH benefit package as these services are not currently covered under the State Plan or under any traditional state Medicaid services. Finally, the state is also requesting the authority to claim federal matching funds for incentive payments made to providers for linking comprehensive assessments for physical and behavioral health.**

**INVESTMENT AND SUSTAINABILITY**

**Initial federal investment is critical to our ability to implement a successful program that will evolve into a self-sustaining program, continuing long after the Demonstration. By the end of the Demonstration period, the program will be self-sustaining and no longer require upfront investment above the Federal Medical Assistance Percentage (FMAP) coverage. The state has developed a sustainability plan that will generate future savings by creating a system of early intervention, diverting individuals from accessing intensive behavioral health services as the result of a crisis event. The state is also investigating other sources of funding such as through intergovernmental transfers and certified public expenditures.**



* Medicaid-eligible includes the CHIP population

**SUMMARY OF PROGRAM ELEMENTS**

**This five year Demonstration will:**

1) **Maintain Medicaid state plan eligibility;**
2) **Maintain Medicaid state plan benefits;**
3) **Allow the state to provide an early behavioral health evaluation to a subset of Medicaid beneficiaries, administered by traditional and non-traditional providers in a variety of locations;**
4) **Allow the state to provide the REACH program only to the Medicaid- eligible youth who qualify through the early behavioral health evaluation and to claim federal matching funds for the REACH program;**
5) **Allow the state to reimburse traditional and non-traditional professionals for the early behavioral health evaluations provided to Medicaid-eligible youth in a variety of settings;**
6) **Allow the state to receive federal match for a PMPM and incentive payment for the REACH program;**
7) **Allow the state to receive federal match for an incentive payment for linking comprehensive physical and behavioral health assessments; and**
8) **Generate cost efficiencies for the state to support the long-term sustainability of the Medicaid program.**

2) Include the rationale for the Demonstration (if additional space is needed, please supplement your answer with a Word attachment);

**Nevada is the ideal setting for the interventions proposed under this Demonstration because the need is so vast in our state. Most national studies identify Nevada as a state with several "high risk" markers and a state that has not effectively addressed child and family well-being. In Nevada, suicide is the second leading cause of death for 15 to 24 year olds and the third leading cause for youth ages 10-14 years (NV DHHS, 2009). Nevada ranks last for high school graduation with a high drop-out rate (America's Health Rankings, 2014) and Nevada has the 15th highest teen birth rate in the nation (NCSL.org, 2011). Nevada recently ranked 49th in the country for "needing but not receiving mental health services among youth" (Parity or Disparity: The State of Mental Health in America: 2015). It is the highest in the nation for youth with "prevalence of" and "ongoing" emotional, behavioral, and developmental issues and for youth consistently uninsured.**

**Given the significant need, Nevada has made strengthening its behavioral health system a top priority. This 1115 Demonstration waiver is linked with the Governor's priority to improve behavioral health access and services for youth in Nevada as well**



* Medicaid-eligible includes the CHIP population

**as a number of ongoing initiatives geared at improving the mental and behavioral health of our youth. Specifically, the Department of Health and Human Services (DHHS) has obtained a number of grants that align with the goal of this Demonstration to achieve a system of care that is rooted in early detection and intervention. For example, these projects will assist the state to expand the capacity of community-based providers, which will be a critical element to ensuring Medicaid-eligible youth who are evaluated and determined to be rising risk or at risk will be able to access necessary services.**

**The following behavioral health initiatives in Nevada compliment the activities of this Demonstration in which the ideal environment is set to achieve and support the state's vision of a transformed behavioral health system:**

- **School Social Workers: The Nevada legislature approved $16 million over the biennium to place social workers in schools to improve access to and evaluation of behavioral health disorders.**

- **Centers for Medicare and Medicaid State Innovation Model (SIM): The State was awarded $2 million to design a State Innovation Model. One of the primary focuses of the State's SIM grant is the child and youth population which provides perfect timing for a true transformation in healthcare for our younger Nevadans.**

- **Mental Health Block Grant: In Nevada's mental health block grant the state has set aside 5% to coordinate a statewide strategic plan for First Episode Psychosis programs using the Recovery After an Initial Schizophrenia Episode (RAISE) model for coordinated specialty care. This initiative falls within the system of care the state is establishing, focused on the child or youth and following him or her before a diagnosis through services, treatment and finally recovery.**

- **SAMSHA System of Care Grant: This grant will help the state transition from being a direct service provider of behavioral health services to developing and supporting an adequate system of care within the community. Recent legislation passed by the Governor and State legislature helped further our community-based, non-traditional service providers. This initiative will support an infrastructure that can support the proposed REACH program.**

- **Tribal Health: This Section 1115 Demonstration waiver concept was presented at a recent Tribal Consultation with the DHCFP, and their board**



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**members responded positively to the information; there was discussion of integrating their current behavioral health program with the Demonstration's program as an effort to collaborate.**

**In changing our system from crisis to early intervention, the state is seeking to improve the lives of its youth and reduce the costs associated with their treatment. Research supports the value of finding and addressing behavioral health issues early in a youth's life in terms of reducing the chances of the condition elevating as well as avoiding the higher level costs that accompany such diagnoses.**

**For example:**

- **Preliminary results from the Early Detection and Intervention for the Prevention of Psychosis Program (EDIPP) program funded by the Robert Wood Johnson Foundation, which identifies young people with warning symptoms of mental disorders and gets them into treatment, show the prevention model is working at reducing hospitalization rates for severe mental disorders among teens and young adults as well as reduced rates of psychotic episodes in young people with early symptoms (Robert Wood Johnson Foundation, 2013).**

- **The correlation between mental and physical health is well documented. Individuals with mental illnesses are four times more likely to die from treatable illnesses than those without mental illness and 58 more times more likely to die before the age of 50 (Disability Rights Commission, 2005). An analysis of Medicaid expenditures for over 29 million children found that Medicaid costs for physical and behavioral health services were five times higher for children using behavioral health services than for Medicaid children in general. Additionally, research indicates properly diagnosing and treating mental illness saves money by treating the underlying disorders that can be at the root of medical overutilization (Shemo, 1986).**

- **Among 10 effective school-based life skills programs, the average return on investment exceeded $15 to $1. That is, every dollar spent on these programs returned an average of $15 dollars per student. The probable costs and cost savings involved in implementing a composite of these programs for middle school youth ages 12-14 nationwide were estimated. The average program would delay more than a million initiations of alcohol, cocaine, marijuana, or tobacco use by youth for an average of two years. Its costs would be $220 per pupil (Miller and Hendrie, 2008).**



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- **Prevention and early intervention efforts targeted to children, youth and their families have been shown to be beneficial, cost-effective and reduce the need for more costly interventions and outcomes such as welfare dependency and juvenile detention. For every $1 invested in mental health treatment, $3.68 is saved in reduced criminal activity and hospitalizations. (SCOPE, *Mental Health Study Group Report*, 2003).**

- **The cost-effectiveness of behavioral health screenings is well-documented. Screening costs ranged from $8.88 to $13.64 per enrolled student, depending on the prevalence of positive screens in a school. Of students who were referred for services, 72% were linked to supportive services within six weeks. Cost effectiveness was estimated to be $416.90 per successful linkage when 5% of students screened positive and $106.09 when 20% screened positive (Kuo, Stoep, McCauley and Kernic, 2010).**

**In summary, the rationale for this Demonstration is the present need for a system transformation and a state that is ready for change. Research all points to supporting the vision of a system built on prevention and early intervention. Numerous studies document cost savings tied to similar initiatives, however, regardless of the savings, the state's priority is the best health outcomes for Nevada's youth.**

3) Describe the hypotheses that will be tested/evaluated during the Demonstration's approval period and the plan by which the State will use to test them (if additional space is needed, please supplement your answer with a Word attachment);

**The primary hypothesis the state is testing during the Demonstration's approval period is that providing an early behavioral health evaluations to 7th graders will help to identify those likely to develop serious behavioral health issues at a point when early intervention efforts are possible. Providing early interventions using the results from the CANS evaluation and the predictive algorithm and establishing a system of care around these evaluations will lead to fewer instances of serious behavioral health issues for youth in Nevada, and will create cost savings as current high-cost intensive treatment interventions will be avoided, and early identification and prevention services interventions are provided.**

**With the help of an independent evaluator, the DHCFP will develop a plan for evaluating and improving the effectiveness of this behavioral health program for Medicaid-eligible youth, including key outcome and improvement measures. The DHCFP will identify validated Healthcare Effectiveness Data and Information Set**



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**(HEDIS) and /or External Quality Review Organization (EQRO) measures that adequately assess the impact of the program including reductions in higher levels of behavioral and physical health care and increases in early intervention service utilization. The state expects that by intervening early and providing an early intervention program when necessary, some youth will avoid the need for accessing more intensive services at a later date. Accordingly, the DHCFP will measure the impact of the Demonstration in terms of the reduction of: Emergency Room (ER) utilization, psychiatric hospitalizations, and Residential Treatment Center (RTC) stays or length of stay. These areas of measurement were chosen because they are high-cost, high level services where the largest improvement in health outcomes and cost reduction are expected. As listed above, literature supports the theory that early interventions can reduce the need for higher level services. The state will also assess how improved behavioral health can positively impact one's physical health in terms of comprehensive care. The DHCFP will examine the impact this program has on the number of Early Periodic Screening Diagnosis and Treatment (EPSDT) visits and improved access to other services, such as dental care. The state will evaluate the social impact of the REACH program by measuring the impacts to social determinants of health, such as truancy, usage of the juvenile justice system, high school drop-out and graduation rates, and future employment. A formal Evaluation Plan will be submitted to CMS.**

4) Describe where the Demonstration will operate, i.e., statewide, or in specific regions within the State. If the Demonstration will not operate statewide, please indicate the geographic areas/regions of the State where the Demonstration will operate (if additional space is needed, please supplement your answer with a Word attachment);

**While Demonstration only applies to Medicaid-eligible youth, this program is tied to a statewide mandate that will be initiated by our State Chief Medical Officer. The statewide mandate will ensure that all youth receive an early behavioral health evaluation prior to entering the 7th grade. Medicaid-eligible youth will participate in the REACH program- the early behavioral health evaluation and early intervention services covered under the Demonstration. Those enrolled in private health insurance will be covered by their qualified health plans or other sources of insurance or funding, and funds to cover the uninsured and undocumented will be identified by the state. Nevada currently has a statewide mandate that all youth receive their Tdap vaccine prior to entry into the 7th grade which has been a model for this early behavioral health evaluation mandate.**



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**The initial target is for all Medicaid-eligible individuals entering 7th grade to receive the evaluation, and each following year, the youth enrolling in 7th grade will obtain their early behavioral health evaluation prior to entering 7th grade. While the evaluation and REACH program only applies to the first year of enrollment in the program, the youth will be tracked for the length of the Demonstration. By the end of the Demonstration, all youth who entered 7th grade in Nevada and who were eligible for Medicaid during the Demonstration period will have received the early behavioral health evaluation and REACH program interventions, if appropriate.**

5) Include the proposed timeframe for the Demonstration (if additional space is needed, please supplement your answer with a Word attachment); and

**The DHCFP is requesting a five year Demonstration plus an additional "year zero" at the beginning of the program for an approximate nine month ramp up period to ensure the Medicaid-eligible youth will receive an early behavioral health evaluation at the start of the new school year beginning in August 2016. After year one, the goal is to provide the early behavioral health evaluations in the spring, prior to the end of the school year. The following chart presents the proposed timeline:**

| DEMONSTRATION YEAR | ACTIVITY | DATES |
|---|---|---|
| **0** | **Implementation:**<br>• **MMIS update,**<br>• **Evaluator training/Medicaid enrollment,**<br>• **Statewide Database development,**<br>• **Statewide early behavioral health evaluation mandate,**<br>• **Evaluation Plan developed**<br>• **Hire additional DHCFP staff** | **November, 2015-July 2016** |
| **1** | **Enroll Medicaid-eligible youth who are entering 7th grade in Demonstration, evaluation & REACH;** | **August, 2016-July, 2017** |



* Medicaid-eligible includes the CHIP population

| | | |
|---|---|---|
| | **Watch and Wait reevaluated in 6 months. March, April and May, the evaluations for the soon-to-be 7th graders will begin. Tracking 10-15 years olds.** | |
| **2** | **Enroll new Medicaid-eligible 7th graders in Demonstration, evaluation & REACH;<br>Watch and Wait reevaluated in 6 months; evaluate new 7th graders in March, April & May; Tracking 10-16 year olds.** | **August, 2017-July, 2018** |
| **3** | **Enroll new Medicaid-eligible7th graders in Demonstration, evaluation & REACH;<br>Watch and Wait reevaluated in 6 months; evaluate new 7th graders in March, April & May; Tracking 10-17 year olds.** | **August, 2018-July, 2019** |
| **4** | **Enroll new Medicaid-eligible 7th graders in Demonstration, evaluation & REACH services;<br>Watch and Wait reevaluated in 6 months; evaluate new 7th graders in March, April & May; Tracking 10-18 years olds.** | **August, 2019-July, 2020** |
| **5** | **Enroll new Medicaid-eligible 7th graders in Demonstration, evaluation & REACH services;<br>Watch and Wait** | **August, 2020-July, 2021** |



* Medicaid-eligible includes the CHIP population

| | | |
|---|---|---|
| | **reevaluated in 6 months; evaluate new 7th graders in March, April & May; Tracking 10-19 years olds. Complete Evaluation Plan assessment** | |

6) Describe whether the Demonstration will affect and/or modify other components of the State's current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems (if additional space is needed, please supplement your answer with a Word attachment).

- **Subject to CMS approval, the DHCFP will develop rates for (1) providers administering early behavioral health evaluations and to Medicaid-eligible youth; and (2) the REACH's PMPM program for providers who render this package of services to the rising risk population who are Medicaid-eligible.**
- **The DHCFP would like to provide incentive payments for comprehensive physical and behavioral health assessments, referrals and completion of services. These incentives will take the form of additional payments to behavioral health and primary care providers who make appropriate referrals to each other and whose patients follow through with the referral visit.**
- **The DHCFP will develop incentive payments for the REACH Coordinators, who are those providers who monitor the rising risk youth throughout the entire REACH program to completion.**

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**Suicide Prevention Resource Center, Nevada Department of Health and Human Services, Retrieved on July 27, 2015 from http://www.sprc.org/grantees/nevada-department-health-and-human-services.**



* Medicaid-eligible includes the CHIP population

## Section II – Demonstration Eligibility

*This section should include information on the populations that will participate in the Demonstration, including income level. In accordance with 42 CFR 431.412(a)(ii), the information identified in this section must be included in a state's application in order to be determined complete. Specifically, this section should:*

1) Include a chart identifying any populations whose eligibility will be affected by the Demonstration (an example is provided below; note that populations whose eligibility is not proposed to be changed by the Demonstration do not need to be included).

   Please refer to Medicaid Eligibility Groups: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-Eligibility-Groups.pdf when describing Medicaid State plan populations, and for an expansion eligibility group, please provide the state name for the groups that is sufficiently descriptive to explain the groups to the public.

   **This Demonstration will not affect any beneficiary's Medicaid eligibility. Additional benefits (CANS evaluation and the REACH program) will be provided to the demonstration's target population.**

2) Describe the standards and methodologies the state will use to determine eligibility for any populations whose eligibility is changed under the Demonstration, to the extent those standards or methodologies differ from the State plan (if additional space is needed, please supplement your answer with a Word attachment);

   **In addition to the State Plan services they are already eligible to receive, Medicaid-eligible youth entering the 7th grade will be eligible for an early behavioral health evaluation [a modified version of the Child and Adolescent Needs and Strengths (CANS) evaluation].***

   **Based upon the results of the evaluation, each youth will fall into one of four categories:**

   1. **No Risk**
   2. **Watch and Wait**
   3. **Rising Risk**
   4. **At Risk**

   **These categories determine what happens next for the Demonstration's target population:**



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| Category | Eligibility |
|---|---|
| **No Risk** | **No further action** |
| **Watch and Wait** | **Re-evaluated in 6 months. If youth escalates to Rising Risk, he/she will be referred to the REACH program.** |
| **Rising Risk** | **REACH program-eligible** |
| **At Risk** | **Referral to appropriate clinical provider or mobile crisis unit to determine immediate and future needs, if in crisis.** |

**Under the Demonstration, those identified through the CANS evaluation as rising risk will be eligible for the REACH program, a program comprised specifically of non-State Plan services, focusing on the needs of the rising risk and his/her family's needs. Research suggests this population can be positively impacted prior to the escalation of a behavioral health diagnosis. (See Section I, Q2 for additional information on research).**

3) Specify any enrollment limits that apply for expansion populations under the Demonstration (if additional space is needed, please supplement your answer with a Word attachment);

**There is no enrollment limit for those beneficiaries who meet the eligibility criteria (as noted above).**

**Each subsequent year of the demonstration will add newly eligible 7th graders (eligible for Medicaid) to the demonstration population. The REACH program is only available to the rising risk population during their first year in the Demonstration. Each subsequent year of the demonstration, incoming youth are evaluated and a new rising risk group is identified.**

4) Provide the projected number of individuals who would be eligible for the Demonstration, and indicate if the projections are based on current state programs (i.e., Medicaid State plan, or populations covered using other waiver authority, such as 1915(c)). If applicable, please specify the size of the populations currently served in those programs (if additional space is needed, please supplement your answer with a Word attachment);

**The state estimates approximately 14,000 youth (based upon FY15 CMS-416 data) will be eligible for the CANS evaluation in the first year of the demonstration. This represents all Medicaid-eligible youth just prior to**



* Medicaid-eligible includes the CHIP population

**entering the 7th grade. Each year of the Demonstration, the new 7th graders will be introduced into the CANS evaluation phase of the program. This enrollment number is estimated to be similar to the first year's enrollment based upon the current enrollment in grades first through sixth. Estimates are as follows:**

| Category | Percentage Estimate | Total for Years 1-5 (per year) |
|---|---|---|
| **No Risk** | **60%** | **8,400** |
| **Watch and Wait** | **20%** | **2,800** |
| **Rising Risk** | **15%** | **2,100** |
| **Crisis** | **5%** | **700** |

**Based upon these estimates, the number of youth eligible for the REACH program (those identified as rising risk) will be approximately 10,500 over the course of the Demonstration, with the number of individuals utilizing the REACH program in a given year rising each subsequent year of the Demonstration.***

***See Section III for a description of the service package and its limitations.***

5) To the extent that long term services and supports are furnished (either in institutions or the community), describe how the Demonstration will address post-eligibility treatment of income, if applicable. In addition, indicate whether the Demonstration will utilize spousal impoverishment rules under section 1924, or will utilize regular post-eligibility rules under 42 CFR 435.726 (SSI State and section 1634) or under 42 CFR 435.735 (209b State) (if additional space is needed, please supplement your answer with a Word attachment);

**N/A**

6) Describe any changes in eligibility procedures the state will use for populations under the Demonstration, including any eligibility simplifications that require 1115 authority (such as continuous eligibility or express lane eligibility for adults or express lane eligibility for children after 2013) (if additional space is needed, please supplement your answer with a Word attachment); and

**N/A**

7) If applicable, describe any eligibility changes that the state is seeking to undertake for the purposes of transitioning Medicaid or CHIP eligibility standards to the



* Medicaid-eligible includes the CHIP population

methodologies or standards applicable in 2014 (such as financial methodologies for determining eligibility based on modified adjusted gross income), or in light of other changes in 2014 (if additional space is needed, please supplement your answer with a Word attachment).

**N/A**



* Medicaid-eligible includes the CHIP population

## Section III – Demonstration Benefits and Cost Sharing Requirements

*This section should include information on the benefits provided under the Demonstration as well as any cost sharing requirements. In accordance with 42 CFR 431.412(a)(ii), the information identified in this section must be included in a state's application in order to be determined complete. Specifically, this section should:*

1) Indicate whether the benefits provided under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

   **The Demonstration utilizes an innovative approach to prevention and early intervention for Nevada's rising risk youth. Through numerous stakeholder meetings, it was determine that a state-modified version of the Child and Adolescent Needs and Strengths (CANS) evaluation will be administered to all youth entering 7th grade. Nevada's current State Plan does not cover the CANS evaluation administered by non-traditional providers. As such, the CANS evaluation administered by traditional and non-traditional providers will be included under the Demonstration, allowing these providers to administer the CANS evaluation to the target population. Nevada's behavioral health professionals are stretched thin to meet the demanding needs of our current Medicaid services. By incorporating non-traditional providers including, school psychologists, school nurses, school social workers, school behavior specialists and behavioral specialist aides, community health workers, juvenile justice staff and parole & probation staff, we are utilizing providers located where the youth are located. One goal of this program is to identify our rising risk youth by expanding Nevada's network of non-traditional providers. This improves access to care and addresses a provider shortage issue.**

   **Once the CANS evaluation is complete, youth that are rising risk will be referred by the provider administering the evaluation to a REACH Coordinator. The REACH Coordinator monitors the youth through the REACH program, ensuring its completion. A bonus incentive will be awarded to the REACH coordinator once the youth completes the entire program in the time allotted.**

   **The CANS evaluation not only assigns a risk score to a youth, but also produces a predictability score that projects where the youth would end up if no interventions occurred. This feature will be used to reflect "with" and "without waiver" scores for the rising risk youth completing the REACH program. The REACH program includes a dynamic set of services unique to this Demonstration including:**



* Medicaid-eligible includes the CHIP population

1) **REACH Coordination: provides coordination of the REACH program, provides mentoring, coaching, education and resources to REACH program children/families.**
2) **Community Integration: health literacy, social supports, vocational supports, and recreational supports based on child/family needs in order to maintain or improve level of risk.**
3) **Positive Youth Development: opportunities for youth to build, enhance, and maintain skills, assets, and abilities.**
4) **Parent Coaching: assists with daily life skills and supports achievement of objectives to maintain/reduce risk.**

**All of these components will be embedded in a program the rising risk will complete over three to six months.**

2) Indicate whether the cost sharing requirements under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

**N/A**

3) If changes are proposed, or if different benefit packages will apply to different eligibility groups affected by the Demonstration, please include a chart specifying the benefit package that each eligibility group will receive under the Demonstration (an example is provided):

**Below is a chart that indicates which service package each category or determination is eligible for under the demonstration:**

| Category | Demonstration Benefit |
|---|---|
| **No Risk** | **Initial CANS evaluation** |
| **Watch and Wait** | **Initial CANS evaluation+ reevaluate in 6 months. If reevaluation puts a WW individual into Rising Risk, they become eligible for the REACH program.** |
| **Rising Risk** | **Initial CANS evaluation + REACH program participation** |
| **At Risk** | **Initial CANS evaluation + appropriate clinical provider or mobile crisis team intervention (outlined via existing State Plan)** |



* Medicaid-eligible includes the CHIP population

4) If electing benchmark-equivalent coverage for a population, please indicate which standard is being used:

**N/A**

5) In addition to the Benefit Specifications and Qualifications form: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Benefit-Specifications-and-Provider-Qualifications.pdf, please complete the following chart if the Demonstration will provide benefits that differ from the Medicaid or CHIP State plan, (an example is provided).

**See attached Benefit Specifications and Qualifications forms. See Attachment III-1 for the Demonstration's service package specifications in comparison to State Plan services.**

6) Indicate whether Long Term Services and Supports will be provided.

**N/A**

7) Indicate whether premium assistance for employer sponsored coverage will be available through the Demonstration.

**N/A**

8) If different from the State plan, provide the premium amounts by eligibility group and income level (if additional space is needed, please supplement your answer with a Word attachment).

**N/A**

9) Include a table if the Demonstration will require copayments, coinsurance and/or deductibles that differ from the Medicaid State plan (an example is provided):

**N/A**

10) Indicate if there are any exemptions from the proposed cost sharing (if additional space is needed, please supplement your answer with a Word attachment).

**N/A**



* Medicaid-eligible includes the CHIP population

## Section IV – Delivery System and Payment Rates for Services

*This section should include information on the means by which benefits will be provided to Demonstration participants. In accordance with 42 CFR 431.412(a)(ii), a description of the proposed healthcare delivery system must be included in a state's application in order to be determined complete. Specifically, this section should:*

1) Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP State plan:

**The Demonstration's delivery system consists of two components:**

1. **The modified Child Adolescent Needs and Strength (CANS) evaluation; and**
2. **The Resources for Early Advancement of Child Health (REACH) program**

**See Attachment III-1 for chart of services.**

2) Describe the delivery system reforms that will occur as a result of the Demonstration, and if applicable, how they will support the broader goals for improving quality and value in the health care system. Specifically, include information on the proposed Demonstration's expected impact on quality, access, cost of care and potential to improve the health status of the populations covered by the Demonstration. Also include information on which populations and geographic areas will be affected by the reforms (if additional space is needed, please supplement your answer with a Word attachment);

**Nevada is undertaking an overall system transformation by moving from a crisis-based system to an early intervention and prevention system. This transformation will result in delivery system reforms, most notably the introduction of a mandated behavioral health evaluation for all 7th graders, to be administered by both traditional and non-traditional providers. Schools, Family Resource Centers, juvenile justice, parole and probation, Federally Qualified Health Centers (FQHCs), school-based health centers and after school programs are all possible sites where the rising risk population could be identified and easily accessed, which is why the state is transforming its delivery system to include these non-traditional providers and settings as locations for the CANS evaluation to be administered. Traditional providers – both physical and behavioral health providers – will also administer the CANS evaluation in their usual practice settings and refer to appropriate services. By tapping into both traditional and non-traditional providers for conducting the CANS evaluation, the state's capacity for behavioral health evaluation expands. The current services and settings not included under State Plan include: the delivery system that differs from the State Plan, including the settings for the CANS**



* Medicaid-eligible includes the CHIP population

**evaluations, the CANS evaluation process and the use of non-traditional providers for conducting the evaluations and referrals to care. The CANS can be modified based upon the needs of its population and the time constraints within the schools. Additionally, the CANS provides a predictive score that suggests where a youth will end up if no further interventions are provided. Traditional providers such as pediatricians will also provide the CANS evaluation and refer for services. Based on the results of their screening, youth will be divided into four groups: (1) no risk, (2) watch and wait, (3) rising risk and (4) at risk.**

**Youth who are in the no risk category have completed the process and no further action will be taken. Youth who are in the watch and wait category will be re-evaluated in six months. Depending on the score, they will remain in the watch and wait or move up to either the rising risk or at risk category.**

**When a youth is determined to be rising risk, the REACH Coordinator will monitor and manage the rising risk youth through the REACH program. The REACH Coordinators will be incentivized for the completion of the REACH program. As part of this system of care, the REACH Coordinator will assess and manage the rising risk youth through a program that includes:**

1) **REACH Coordination: provides coordination of the REACH program, provides mentoring, coaching, education and resources to REACH program children/families.**
2) **Community Integration: health literacy, social supports, vocational supports, and recreational supports based on child/family needs in order to maintain or improve level of risk.**
3) **Positive Youth Development: opportunities for youth to build, enhance, and maintain skills, assets, and abilities.**
4) **Parent Coaching: assists with daily life skills and supports achievement of objectives to maintain/reduce risk.**

**The follow-up care received by rising risk youth will be tracked through claims data that identifies, through codes and modifiers, services specific to this program. The REACH program is designed to provide early intervention for the rising risk in the 7th grade. There will be procedures in place to provide additional intervention services to those with additional needs. If it is determined that an escalation of the condition has occurred, a referral process will ensure the youth is reevaluated and appropriately referred. If a youth receives a behavioral health diagnosis, the youth will have access to State Plan services.**



* Medicaid-eligible includes the CHIP population

**For youth found to be at risk, the REACH Coordinator will refer the child and his/her family to a therapeutic clinical provider unless the child is in crisis in which case a prompt referral will be made to the mobile crisis team. The mobile crisis team has an already established protocol that will be followed. It is critical that all providers who perform the evaluations be a part of a comprehensive of system of care so that children on both ends of the spectrum receive appropriate services.**

**Each outcome resulting from the CANS evaluation leads to a process referring the individual to the appropriate level of services**

3) Indicate the delivery system that will be used in the Demonstration by checking one or more of the following boxes:

**The Medicaid delivery system in Nevada has approximately 70% of the Medicaid and CHIP population included in managed care (urban Clark and Washoe counties). All Medicaid- and CHIP- eligible youth will be included in the Demonstration, including managed care and fee-for-service beneficiaries, however, the Demonstration's screening and service package will be carved out of managed care. The youth included in the Demonstration meet the program criteria (age and grade level), making him or her eligible for a program-specific evaluation and service package. This Demonstration and its associated claims will be covered by fee-for-service. Following the five year demonstration, the state will evaluate the program for sustainability. The plan is to add the Nevada version of the CANS evaluation, the REACH program and Nevada's non-traditional providers to the State Plan based on the results of the program evaluation and identified best practices for improved beneficiary outcomes and reduced costs.**

**Managed care will maintain data on their beneficiaries participating in the REACH program which will be reviewed during the post-Demonstration Evaluation. The state will use the information gained throughout the demonstration to assist its two managed care organizations in ensuring their beneficiaries receive the best possible coordinated care.**

4) If multiple delivery systems will be used, please include a table that depicts the delivery system that will be utilized in the Demonstration for each eligibility group that participates in the Demonstration (an example is provided). Please also include the appropriate authority if the Demonstration will use a delivery system (or is currently seeking one) that is currently authorized under the State plan, section 1915(a) option, section 1915(b) or section 1932 option:



* Medicaid-eligible includes the CHIP population

**Fee-for-service will be the sole delivery system for this Demonstration's screening and service package. For those program-eligible individuals enrolled in managed care, the package will be carved out and will not be included in capitation rates. At the end of the five-year Demonstration when the program becomes independent of the waiver, the program success will be evaluated and a decision made if this program will be transitioned into the managed care program and be included in the capitation rates.**

5) If the Demonstration will utilize a managed care delivery system:

**N/A;**

a) Indicate whether enrollment be voluntary or mandatory. If mandatory, is the state proposing to exempt and/or exclude populations (if additional space is needed, please supplement your answer with a Word attachment)?

b) Indicate whether managed care will be statewide, or will operate in specific areas of the state (if additional space is needed, please supplement your answer with a Word attachment);

c) Indicate whether there will be a phased-in rollout of managed care (if managed care is not currently in operation or in specific geographic areas of the state. If additional space is needed, please supplement your answer with a Word attachment);

d) Describe how will the state assure choice of MCOs, access to care and provider network adequacy (if additional space is needed, please supplement your answer with a Word attachment); and

e) Describe how the managed care providers will be selected/procured (if additional space is needed, please supplement your answer with a Word attachment).

6) Indicate whether any services will not be included under the proposed delivery system and the rationale for the exclusion (if additional space is needed, please supplement your answer with a Word attachment).

**N/A**

7) If the Demonstration will provide personal care and/or long term services and supports, please indicate whether self-direction opportunities are available under the Demonstration. If yes, please describe the opportunities that will be available,



* Medicaid-eligible includes the CHIP population

and also provide additional information with respect to the person-centered services in the Demonstration and any financial management services that will be provided under the Demonstration (if additional space is needed, please supplement your answer with a Word attachment).

**N/A**

8) If fee-for-service payment will be made for any services, specify any deviation from State plan provider payment rates. If the services are not otherwise covered under the State plan, please specify the rate methodology (if additional space is needed, please supplement your answer with a Word attachment);

**The payment methodology for the CANS evaluation will not deviate from existing State Plan provider payment rates. This service would fall under an applicable rate methodology already outlined in Attachment 4.19 of the Nevada Medicaid State Plan. The existing rate methodologies are based on type of service provided.**

**A payment will be made to providers administering the CANS evaluation to Medicaid-eligible youth. In addition, a PMPM payment will be made to providers who render the REACH program for the rising risk population.**

**The REACH program will consist of:**

1) **REACH Coordination: provides coordination of the REACH program, provides mentoring, coaching, education and resources to REACH program children/families.**
2) **Community Integration: health literacy, social supports, vocational supports, and recreational supports based on child/family needs in order to maintain or improve level of risk.**
3) **Positive Youth Development: opportunities for youth to build, enhance, and maintain skills, assets, and abilities.**
4) **Parent Coaching: assists with daily life skills and supports achievement of objectives to maintain/reduce risk.**

**The state is requesting CMS' direction on devising this methodology.**

9) If payment is being made through managed care entities on a capitated basis, specify the methodology for setting capitation rates, and any deviations from the payment and contracting requirements under 42 CFR Part 438 (if additional space is needed, please supplement your answer with a Word attachment); and

**N/A**



* Medicaid-eligible includes the CHIP population

10) If quality-based supplemental payments are being made to any providers or class of providers, please describe the methodologies, including the quality markers that will be measured and the data that will be collected (if additional space is needed, please supplement your answer with a Word attachment).

**The DHCFP seeks to incentivize our REACH Coordinators for monitoring the rising risk youth throughout the entire REACH program, ensuring completion of the three month program over a maximum of six months. An incentive payment will be awarded to the REACH Coordinator for each rising risk youth who completes the entire REACH program. The emphasis is to promote active program involvement over a determined amount of time. This process also includes database maintenance to ensure timely, accurate data are collected on the Demonstration population.**

**The state also would like guidance from CMS on developing an incentive program for comprehensive assessments linking physical and behavioral health providers to promote holistic care. For example, the state would like to increase EPSDT screenings and expand these screenings to ensure youth will receive a behavioral health assessment along with their well- child exams. The state is interested in developing an incentive payment program to encourage providers to follow this holistic model of care.**



* Medicaid-eligible includes the CHIP population

## Section V – Implementation of Demonstration

*This section should include the anticipated implementation date, as well as the approach that the*
*State will use to implement the Demonstration. Specifically, this section should:*

1) Describe the implementation schedule. If implementation is a phase-in approach, please specify the phases, including starting and completion dates by major component/milestone (if additional space is needed, please supplement your answer with a Word attachment);

**The state is requesting a five year Demonstration plus an initial "year zero" for start-up activities. Please refer to the chart presented in Section I, question five for an outlined timeframe of the five plus zero year activities.**

**IMPLEMENTATION SCHEDULE (TO BE COMPLETED IN YEAR ZERO PRIOR TO PROGRAM GOING LIVE):**

- **MMIS changes to accommodate reimbursement of CANS evaluation and PMPM payment for the REACH program to all applicable provider types.**
- **New Medicaid provider enrollment and training**
- **Hire DHCFP staff to support the Demonstration activities**
- **Hire training staff to work with schools on program implementation**
- **Initial consultation with CANS developer; modification of CANS evaluation to program needs**
- **Initial training on CANS evaluation and referrals for providers who perform the evaluation (REACH Coordinators).**
- **Development of REACH program with participating providers**
- **Development of statewide database for tracking evaluations and REACH activities (similar to Nevada WebIZ for immunizations)**
- **Work with outside vendor to develop Evaluation Plan for the Demonstration**
- **Develop Quality Improvement methodology for the Demonstration**
- **Program Readiness Review**
- **Notification of enrollment process developed (target to parents)**

2) Describe how potential Demonstration participants will be notified/enrolled into the Demonstration (if additional space is needed, please supplement your answer with a Word attachment); and

**A parental notification process will be developed during Year Zero of the program implementation.**

3) If applicable, describe how the state will contract with managed care organizations to provide Demonstration benefits, including whether the state needs to conduct a procurement action (if additional space is needed, please supplement your answer with a Word attachment).



* Medicaid-eligible includes the CHIP population

**During the Demonstration, the CANS evaluation and REACH program will be a carve out for managed care beneficiaries. Throughout the Demonstration period, the MCOs will be notified of their beneficiaries' enrollment in the program to better coordinate their services and to keep the MCOs aware of the status of their enrollees. For the youth deemed at risk who are enrolled in an MCO, a notification process will be developed in order to provide a "warm hand-off" to the MCOs' behavioral health state plan providers.**



* Medicaid-eligible includes the CHIP population

## Section VI – Demonstration Financing and Budget Neutrality

*This section should include a narrative of how the Demonstration will be financed as well as the expenditure data that accompanies this application. The State must include 5 years of historical data, as well as projections on member month enrollment. In accordance with 42 CFR431.412(a)(iii) and (iv), historical and projected expenditures as well as projected enrollment for the proposed demonstration project must be included in a state's application in order to be determined complete. The additional information requested will be needed before the application can be acted upon.*

Please complete the Demonstration financing and budget neutrality forms, respectively, and include with the narrative discussion. The Financing Form: http://www.medicaid.gov/Medicaid- CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Demo-Financing-Form.pdf includes a set of standard financing questions typically raised in new section 1115 demonstrations; not all will be applicable to every demonstration application. The Budget Neutrality form and spreadsheet: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Budget-Neutrality-Form.pdf includes a set of questions with respect to historical expenditure data as well as projected Demonstration expenditures.

**The DHCFP believes a diversionary budget neutrality model is best suited to meet the Demonstration's Budget Neutrality requirements. The state proposes to demonstrate that the CANS evaluation and REACH program provided through this Demonstration will reduce behavioral health diagnoses resulting in avoided costs for more intensive Medicaid services in a portion of the youth who participate in the Demonstration.**

**Based upon a review of literature, it is believed the Demonstration activities will reduce cost and/or utilization of the following services creating waiver savings: Emergency Room (ER) visits, Inpatient Psychiatric visits and Residential Treatment Centers (RTCs). In Baltimore, MD, an ER diversion project moved psychiatric care out of the ERs and into community-based settings. Within three months, median costs per child were reduced by $600. Psychiatric inpatient rates were also lowered by 42% between the six months prior to intake and the 12 months of follow-up care (State of Maryland, 2011). In Maine, a study showed a net reduction in Medicaid spending of 29% on Residential Treatment Centers (RTCs) when home- and community–based services and targeted case management costs increased (Bruns & Suter, 2010). (See Section I, Q2 for additional references to studies demonstrating cost savings).**



* Medicaid-eligible includes the CHIP population

**While the DHCFP does not currently have a state budget allocation to implement this innovative program, the state believes that there will be sufficient impact both in improved behavioral and physical health for Nevada's Medicaid and CHIP youth beneficiaries. As part of the Demonstration proposal, Nevada is interested in pursuing potential federal investment through Designated State Health Programs (DSHP) to help support the operational and service package start-up costs associated with launching the Demonstration project with a clear plan for long-term state supported program sustainability. Through an initial federal investment using DSHP, the state's belief is that Nevada will be able to generate enough savings to sustain the program beyond the five years of the Demonstration. Beyond the Demonstration period, the state plans to work with its in-state governmental partners to identify and explore options to sustain the Demonstration project through Intergovernmental Transfers (IGTs) and/or Certified Public Expenditures (CPEs). Additionally, the state will seek to demonstrate collateral state savings from specific state only diverted costs to assist in ongoing funding for the waiver program.**

## References


**Bruns, E. J., & Suter, J. C. (2010). Summary of the wraparound evidence base. In E. J. Bruns & J. S. Walker (Eds.),** ***The resource guide to wraparound*****. Portland, OR: National Wraparound Initiative.**

**State of Maryland. (2011).** ***Impact of the PRTF Demonstration Waiver on the State of Maryland: The PRTF Demonstration Grant in Maryland safely provides cost-efficient, community-based care for youth with severe behavioral health needs*****. Baltimore: Author.**




* Medicaid-eligible includes the CHIP population

## Section VII – List of Proposed Waivers and Expenditure Authorities

*This section should include a preliminary list of waivers and expenditures authorities related to title XIX and XXI authority that the State believes it will need to operate its Demonstration. In accordance with 42 CFR 431.412(a)(vi), this section must be included in a state's application in order to be determined complete. Specifically, this section should:*

1) Provide a list of proposed waivers and expenditure authorities; and

**Waivers:**

**<u>Comparability</u> – Section 1902(a)(17) (and related title XXI authority)**

**<u>Amount, Duration and Scope of Services</u> – Section 1902(a)(10)(B) (and related title XXI authority)**

**Expenditure authorities:**

- **To allow the state to receive federal match for the reimbursement of traditional and non-traditional professionals for the early behavioral health evaluations provided to Medicaid-eligible youth in a variety of settings.**
- **To allow the state to receive federal match for a PMPM and incentive payment for the REACH program; and**
- **To allow the state to receive federal match for an incentive payment for linking comprehensive physical and behavioral health assessments.**

2) Describe why the state is requesting the waiver or expenditure authority, and how it will be used.

**Section 1902(a)(17) of the Social Security Act (and related Title XXI authority)**

**The State of Nevada requests that CMS waive the comparability requirements to allow the demonstration evaluation CANS and REACH (Resources for the Early Advancement of Child Health) program to be available to only a select group of children.**



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**Section 1902(a)(10)(B) of the Social Security Act (and related Title XXI authority)**

**The State of Nevada requests that CMS waive section 1902(a)(10)(B)(i) and (ii) of the Social Security Act to the extent necessary to enable the State to target specific waiver services to a select group of children from non-traditional providers.**

**See description of the need to expenditure authorities above.**

Please refer to the list of title XIX and XXI waivers and expenditure authorities: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115 /Downloads/List-of-Waivers-and-Expenditure-Authorities.pdf that the state can reference to help complete this section. CMS will work with the State during the review process to determine the appropriate waivers and expenditures needed to ensure proper administration of the Demonstration.



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## Section VIII – Public Notice

*This section should include information on how the state solicited public comment during the development of the application in accordance with the requirements under 42 CFR 431.408. For specific information regarding the provision of state public notice and comment process, please click on the following link to view the section 1115 Transparency final rule and corresponding State Health Official Letter: [http://medicaid.gov/Medicaid-CHIP-Program-Information/By- Topics/Waivers/1115/Section-1115-Demonstrations.html](http://medicaid.gov/Medicaid-CHIP-Program-Information/By- Topics/Waivers/1115/Section-1115-Demonstrations.html)*

Please include the following elements as provided for in 42 CFR 431.408 when developing this section:
1) Start and end dates of the state's public comment period (if additional space is needed, please supplement your answer with a Word attachment);

**August 7, 2015 through September 6, 2015**

2) Certification that the state provided public notice of the application, along with a link to the state's web site and a notice in the state's Administrative Record or newspaper of widest circulation 30 days prior to submitting the application to CMS (if additional space is needed, please supplement your answer with a Word attachment);

**To be completed at the end of the posting period.**

3) Certification that the state convened at least 2 public hearings, of which one hearing included teleconferencing and/or web capability, 20 days prior to submitting the application to CMS, including dates and a brief description of the hearings conducted (if additional space is needed, please supplement your answer with a Word attachment);

**Public Workshops that meet the Demonstration requirements have been scheduled at the time of the application's posting. This information will be updated at the end of the posting period.**

**Prior to the posting of the Section 1115 Demonstration waiver's application, three workshops were held to discuss this new project and receive stakeholder input. Those meetings were as follows: April 9, 2015 (Program Concept), May 12, 2015 (Screenings) and July 10, 2015 (Services).**

4) Certification that the state used an electronic mailing list or similar mechanism to notify the public. (If not an electronic mailing list, please describe the mechanism that was used. If additional space is needed, please supplement your answer with a Word attachment);



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**To be completed at the end of the posting period.**

5) Comments received by the state during the 30-day public notice period (if additional space is needed, please supplement your answer with a Word attachment);

**To be completed at the end of the posting period.**

6) Summary of the state's responses to submitted comments, and whether or how the state incorporated them into the final application (if additional space is needed, please supplement your answer with a Word attachment); and

**To be completed at the end of the posting period.**

7) Certification that the state conducted tribal consultation in accordance with the consultation process outlined in the state's approved Medicaid State plan, or at least 60 days prior to submitting this Demonstration application if the Demonstration has or would have a direct effect on Indians, tribes, on Indian health programs, or on urban Indian health organizations, including dates and method of consultation (if additional space is needed, please supplement your answer with a Word attachment).

**The DHCFP sent tribal letters on April 17, 2015 to notify them of our collaboration with the National Governor's Association Medicaid Transformation project for behavioral health in youth. On July 7, 2015, the Nevada tribes were sent another letter stating it had been determined that implementation of the project would require a new Section 1115 Demonstration waiver. On July 14, 2015, a report on the 1115 waiver was provided to the tribes at tribal consultation.**

**The Tribal Board responded positively to the Demonstration concept presentation. They indicated they would like to review any evaluation materials for cultural sensitivity. Currently, the tribes have a program titled "Circles" for their youth that addresses behavioral health issues. The board members expressed interest in integrating our program with theirs for the best outcomes.**

If this application is an emergency application in which a public health emergency or a natural disaster has been declared, the State may be exempt from public comment and tribal consultation requirements as outlined in 42 CFR 431.416(g). If this situation is applicable, please explain the basis for the proposed emergency classification and public comment/tribal consultation exemption (if additional space is needed, please supplement your answer with a Word attachment).



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## Section IX – Demonstration Administration

Please provide the contact information for the state's point of contact for the Demonstration application.

Name and Title: **Jenni Bonk, M.S., Social Services Program Specialist III,**

**Nevada Division of Health Care Financing and Policy**

Telephone Number: **(775) 684-3697**

Email Address: **jennibonk@dhcfp.nv.gov**



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| REACH Service | Proposed Waiver Scope of Service | State Plan Service |
|---|---|---|
| **Evaluation** | Child & Adolescent Needs & Strengths (CANS) tool – "The Child and Adolescent Needs and Strengths (CANS) tool is an assessment strategy that is designed to be used for decision support and outcomes management. Its primary purpose is to allow a system to remain focused on the shared vision of serving children and families, by representing children at all levels of the system. http://wcwpds.wisc.edu/cans/Default.aspx | This service will be expanded to non-traditional providers under the waiver. |
| **Re-Evaluation** | Reevaluation of youth "watch and wait" and "rising risk" | Behavioral health screens are a state plan services. However this will be expanded to non-traditional providers under the waiver. |
| **REACH Coordinator** | Provides coordination of the REACH program, provides mentoring, coaching, education and resources to REACH program children/families. | Not a covered state plan service for this target group. |
| **Community Integration** | Health literacy, social supports, vocational supports, and recreational supports based on child/family needs in order to maintain or improve level of risk. | Not a covered state plan service. |
| **Parent Coaching** | Assists with developing family/child coping skills, intrinsic parenting, and support achievement of objectives to maintain/reduce risk. | Not a covered state plan service. |
| **Positive Youth Development** | Opportunities for youth to build, enhance, and maintain skills, assets, and abilities. | Not a covered state plan service. |

Non –traditional provider qualifications proposed for all services:

1. School counselors
2. School Psychologist
3. School Social Worker
4. School Nurse
5. School Psychologist
6. Juvenile Justice (Parole/Probation)
7. Family Resource Centers
8. Behavior Specialists
9. Behavior Specialist aides



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| 1905 Authority | Current State Plan Services | Current State Plan Providers |
|---|---|---|
| **440.20 Rural Health Clinic Services** | Primary care evaluation and management services, well baby check-up visits, USPSTF A&B and ACIP immunizations. | 1. Physicians<br>2. Physician Assistants<br>3. Advance Practitioner Registered Nurse |
| **440.40 EPSDT** | Well baby check-up visits, USPSTF A&B and ACIP immunizations. | 1. Physicians<br>2. Physician Assistants<br>3. Advance Practitioner Registered Nurse |
| **440.50 Physician Services** | Primary care evaluation and management services, well baby check-up visits, USPSTF A&B and ACIP immunizations. | 1. Physicians<br>2. Physician Assistants<br>3. Advance Practitioner Registered Nurse |
| **440.60 Medical or other remedial care provided by licensed practitioners** | Licensed Psychologist services within scope of practice | 1. Psychologists |
| **440.90 Clinic services** | Primary care evaluation and management services, well baby check-up visits, USPSTF A&B and ACIP immunizations. | 1. Physicians<br>2. Physician Assistants<br>3. Advance Practitioner Registered Nurse |
| **440.130 Screening** | USPSTF A&B Screens requires a behavioral health (mental and/or substance abuse) diagnosis | 1. Physicians<br>2. Physician Assistants<br>3. Advance Practitioner Registered Nurse<br>4. Psychologist |
| **440.130 Preventive** | USPSTF A& B Services (i.e. depression screens for pregnant women and immunizations) requires a behavioral health (mental and/or substance abuse) diagnosis | 1. Physicians<br>2. Physician Assistants<br>3. Advance Practitioner Registered Nurse |



* Medicaid-eligible includes the CHIP population

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|---|---|---|
| **440.130 Rehabilitative** | 1. Behavioral Health Screening<br>2. Behavioral Health Assessments<br>3. Peer to Peer Services<br>4. Basic Skills Training<br>5. Psychosocial Training<br>6. Crisis Intervention<br>7. Day Treatment<br>8. Behavioral Health Outpatient Therapy (individual, family and group)<br>9. Substance Abuse Agency Model (Outpatient Services) | 1. Physicians/Psychiatrist<br>2. Physician Assistants<br>3. Advance Practitioner Registered Nurse<br>4. Qualified Mental Health Associate (Degreed professional with mental health experience under supervision of licensed professional)<br>5. Qualified Behavioral Aid (High School para-professional with behavioral health experience under direction of license professional)<br>6. SAAM licensed providers<br>7. Behavioral Health Community Network Providers |
| **Case Management services** | Targeted Case Management Covered Target Groups<br>1. Seriously Mentally Ill<br>2. Severe Emotionally Disturbed<br>3. Developmentally Delayed Ages 0-3<br>4. Intellectual and Developmental Delays and Related Conditions<br>5. Axis I for non SED/non SMI<br>6. Juvenile Justice<br>7. Child Welfare | 1. Registered Nurse<br>2. Qualified Mental Health Associate (Degreed professional with mental health experience under supervision of licensed professional)<br>3. Licensed Behavioral health professional |
| **1915i** | 1. Intensive Outpatient Program<br>2. Partial Hospitalization Program | 1. Behavioral health community network providers<br>2. Outpatient hospital-based behavioral health providers |



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Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

Name of Benefit or Service: **Nevada-modified Child Adolescent Needs and Strengths (CANS) Evaluation**

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

**The CANS is an evaluation tool that examines risk factors for the following:**

- **Mental/behavioral health**
- **Suicidal ideology**
- **Trauma**
- **Substance Abuse**

**The CANS has a prediction algorithm built into it which will provide a "without waiver" estimation for youth who are evaluated with this tool.**

Amount of Benefit/Service – Describe any limitations on the amount of service provided under the Demonstration:
**Each Medicaid/CHIP-eligible child will be evaluated once with the CANS around 7th grade. The watch and wait group will receive a second evaluation six months following the initial CANS evaluation.**

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any: **N/A**

Service Limitations: **See above**

Provider Category:

**Individual**

Description of allowable providers: **traditional and non-traditional**

Provider Qualifications:

**Documented training and certification on performing the Nevada-modified CANS**



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Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

Name of Benefit or Service: **Resources for Early Advancement of Child Health (REACH) program**

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

**The REACH program consists of the following elements:**

1) **REACH Coordination: provides coordination of the REACH program, provides mentoring, coaching, education and resources to REACH program children/families.**
2) **Community Integration: health literacy, social supports, vocational supports, and recreational supports based on child/family needs in order to maintain or improve level of risk.**
3) **Positive Youth Development: opportunities for youth to build, enhance, and maintain skills, assets, and abilities.**
4) **Parent Coaching: assists with daily life skills and supports achievement of objectives to maintain/reduce risk.**

Amount of Benefit/Service – Describe any limitations on the amount of service provided under the Demonstration:

**The REACH program is a three month program. The rising risk youth have up to six months to complete the entire three month program with a lifetime limit of one program enrollment.**

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any: **N/A**

Service Limitations: **See above**

Provider Category:

**Individual**

Description of allowable providers/provider qualifications:



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**License or with education and experience within the field and within the scope of their practice based off of their licensing board**

**The REACH program may be provided by a licensed individual or with approved education and experience within the field and within the scope of their practice based off of their licensing board at the following types of locations:**

**Resource Centers**

**FQHCs/RHCs**

**School s**

**Boys and Girls Clubs**

**Juvenile Justice**

**Primary Care Settings**



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