Section 1115 Demonstration Amendment

Nevada's Treatment of Substance Use Disorders (SUDs) and Serious Mental Illness (SMI)/Severe Emotional Disturbance (SED) Transformation Project

State of Nevada
Department of Health and Human Services
Division of Health Care Financing and Policy

Nevada Department of Health and Human Services
Helping People
It's who we are and what we do.

September 27, 2024

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Governor
State of Nevada

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Section 1: Executive Summary

On December 29, 2022, Nevada received approval for a Section 1115 Demonstration under Title XIX of the Social Security Act (SSA), titled Nevada's Treatment of Opioid Use Disorders (OUD) and Substance Use Disorders (SUD) Transformation Project. This Demonstration allows the State to receive federal Medicaid and CHIP matching funds to support Medicaid and CHIP reimbursement for SUD treatment when provided in an Institution for Mental Disease (IMD). This amendment requests additional expenditure authority to expand Medicaid reimbursement with federal funds under Title XIX and XXI of the SSA to pay IMDs that deliver treatment and services to adults with serious mental illness (SMI) and children with Serious Emotional Disturbance (SED).

Additionally, the State seeks federal expenditure authority to cover services that aim to address certain health-related social needs (HRSNs) for eligible Medicaid and CHIP members. By covering HRSN services, the State believes it can better support eligible members with successful community transitions and stable community living.

Specifically, the state of Nevada is seeking authority to:

- Reimburse for acute inpatient stays in IMDs for Medicaid-eligible individuals ages 21 years to -64 years with a SMI/SED, to include treatment rendered at State psychiatric hospitals. This request is pursuant to legislation passed during the State's 81st legislative session and the opportunity announced by the Centers for Medicare & Medicaid Services (CMS) via State Medicaid Director Letter #18-011.
- Provide access to essential healthcare for children who are diagnosed with a Severe Emotional Disturbance (SED) and require treatment in an IMD, and who would otherwise be ineligible for services under Medicaid or for enrollment in CHIP.
- Pay for HRSN services to provide housing and nutrition supports through an 1115 waiver demonstration authority. This request aligns with CMS' HRSN goals and framework as described in the November 16, 2023, informational bulletin and eligibility criteria will incorporate specific clinical and social risk factors.[1]

This amendment reflects the State's broader efforts to strengthen its continuum of care for individuals with behavioral health (BH) disorders, which, in some cases, includes care and treatment in an IMD setting. This waiver amendment will ensure comparable access to IMDs for Medicaid and CHIP enrollees with SMI/SED, as well as SUD, when necessary, regardless of delivery system.

Currently, managed care organizations can provide up to fifteen days of coverage as an in lieu of service for individuals with SMI residing in an IMD. However, individuals served via fee-for-service (FFS) do not have such access. This demonstration will provide equity in coverage for this population by allowing for reimbursement in an IMD for an average length of stay of up to 30 days, regardless of the delivery system. This will eliminate the inconsistency between managed care and FFS coverage, to ensure comparability among delivery systems.

The State requests an effective date for the amendment of no later than January 1, 2025.

[1] CMCS Informational Bulletin

Section 2: Program Background and Description

A. Demonstration Rationale

The National Institute of Mental Health noted that, in 2021, more than one in five people in the United States are living with a mental illness. SMI causes severe functional impairment in life activities. In 2021, it was estimated that 14.1 million individuals over the age of 18 years suffered from a SMI.[2] A Substance Abuse and Mental Health Services Administration study found that 54.5% of adults aged 18 years or older with SMI had a perceived unmet need for services. Among the 7.2 million adults with SMI and a perceived unmet need for mental health services, 39.7% (or 2.8 million people) did not receive any mental health services, most commonly due to being unable to afford the cost of care.[3]

The following statistics demonstrate the impact of mental health conditions in Nevada:

- Suicide is the ninth leading cause of death in Nevada.[4]
- 474,000 adults in Nevada have a mental health condition, more than eight times the population of Carson City.
- In Nevada, 109,000 adults have a serious mental illness.
- Of the 164,000 adults in Nevada who did not receive needed mental health care, 51% did not because of cost.
- 2,445,591 people in Nevada live in a community that does not have enough mental health professionals.
- Nevadans are over four times more likely to be forced out of network for mental health care than for primary health care, making it more difficult to find care and less affordable due to higher out-of-pocket costs.
- 33,000 Nevadans aged 12 years–17 years have depression.
- 72.4% of Nevadans aged 12 years–17 years, who have depression, did not receive any care in the last year.
- High school students with depression are more than twice as likely to drop out than their peers.
- 11.5% of the people in the state are uninsured, as compared with the national average of 8.6%.[5]

Nearly 7,000 people in Nevada are homeless, and one in three live with SMI.[6] The National Institute for Drug Abuse cites "about half of those who experience a mental illness during their lives will also experience a substance use disorder and vice versa."[7] Individuals with BH disorders are significant utilizers of healthcare services, with approximately one in eight visits to emergency departments (EDs) involving

[2] Mental Illness - National Institute of Mental Health (NIMH) (nih.gov)
[3] 2021 NSDUH Annual National Report | CBHSQ Data (samhsa.gov)
[4] Nevada (cdc.gov)
[5] Percentage of Population Without Health Insurance Coverage by State (census.gov)
[6] NevadaStateFactSheet.pdf (nami.org)
[7] Common Comorbidities with Substance Use Disorders Research Report: References | NIDA (nih.gov)

mental health and/or SUDs.[8] Medicaid is currently the single largest payer for BH services and is increasingly playing a larger role in the reimbursement of SUD services.[9]

According to the Mental Health in America's (MHA's) 2023 State of Mental Health in America report, Nevada currently ranks ninth in the nation for youth and adults with a high prevalence of mental illness and thirty-eighth in access to care. Nevada ranks forty-second- in mental health provider availability, with a provider-to-patient ratio of 2,077:1. For MHA's overall ranking, a combined score across 15 measures for both adult and youth measures, including prevalence and access to care measures, Nevada ranked twenty-ninth among all the states.[10] Additionally, every day, there is an average of 102 individuals waiting in emergency rooms across Nevada for BH services.[11]

Some form of mental illness represents one of the top ten diagnoses in both managed care areas as well as areas with fee-for-service coverage.

[8] Trends in Emergency Department Visits Involving Mental and Substance Use Disorders, 2006-2013 (ahrq.gov)
[9] Behavioral Health Services | Medicaid
[10] https://mhanational.org/issues/2023/ranking-states
[11] Towards a Comprehensive Crisis System in Nevada

Table 1: Top Ten Diagnoses by Utilization Within Each Region

4: Analyze Top 10 diagnoses by utilization within each region.						
Benefit Program: TXIX (Medicaid)			Patients			
Location	Diagnosis Code	Diagnosis Principal	CY 2020	CY 2021	CY 2022	CY 2023
Clark County	R69	Illness, unspecified	466,416	508,294	533,038	569,732
	F70	Mild intellectual disabilities	130,254	128,299	130,662	122,496
	F71	Moderate intellectual disabilities	93,382	86,540	93,015	93,739
	F840	Autistic disorder	92,513	101,933	108,839	127,224
	F8089	Other developmental disorders of speech and language	81,526	101,379	171,138	166,160
	I10	Essential (primary) hypertension	80,368	76,727	76,732	71,220
	F411	Generalized anxiety disorder	62,783	66,684	62,071	74,409
	F82	Specific developmental disorder of motor function	52,746	71,004	82,705	85,890
	Z62898	Other specified problems related to upbringing	52,087	54,110	52,368	50,470
	F331	Major depressive disorder, recurrent, moderate	N/A	51,574	56,254	72,790
Washoe County	F70	Mild intellectual disabilities	31,467	31,648	33,147	31,449
	R69	Illness, unspecified	27,095	23,396	20,739	22,390
	F71	Moderate intellectual disabilities	20,109	19,623	19,318	17,304
	F840	Autistic disorder	16,922	21,109	21,538	26,269
	F79	Unspecified intellectual disabilities	12,279	9,654	7,804	6,554
	F72	Severe intellectual disabilities	9,119	7,519	7,769	7,685
	F802	Mixed receptive-expressive language disorder	8,351	11,731	8,977	28,344
	N186	End stage renal disease	6,840	6,352	6,350	5,253
	F80	Specific Developmental Disorders of Speech and Language	N/A	N/A	N/A	14,782
	R620	Delayed milestone in childhood	N/A	N/A	N/A	5,358
All Other Counties	F70	Mild intellectual disabilities	24,966	25,178	26,578	28,957
	R69	Illness, unspecified	34,137	30,502	25,041	25,334
	F8089	Other developmental disorders of speech and language	13,605	19,549	22,684	18,675
	F411	Generalized anxiety disorder	N/A	15,805	17,684	20,549
	F71	Moderate intellectual disabilities	16,024	14,903	16,687	19,594
	F4310	Post-traumatic stress disorder, unspecified	17,594	16,385	16,676	16,474
	K029	Dental caries, unspecified	N/A	N/A	16,326	15,988
	F1520	Other stimulant dependence, uncomplicated	18,857	18,160	15,526	17,786
	F840	Autistic disorder	N/A	N/A	14,926	17,055
	Z00129	Encounter for routine child health examination without abnormal findings	13,568	14,633	N/A	14,476

These statistics underscore the need to continue to increase availability of targeted services and enhance the mental health care system, as well as ensure processes and systems are in place to link recipients to the right treatment and setting. Expansion of Nevada's current 1115 SUD IMD demonstration waiver to include the SMI population will allow for more integrated treatment efforts toward individuals with mental health and substance use comorbidities.

Nevada identified housing and nutrition as a critical gap in the continuum of care for Medicaid members and their families. According to the National Alliance to End Homelessness, Nevada has the tenth highest homeless rate in the country.[12] Based on information reported by individuals on their Medicaid applications, more than 50,000 Nevadans enrolled in Medicaid face (or have faced) homelessness in

[12] https://endhomelessness.org/homelessness-in-america/homelessness-statistics/state-of-homelessness/

addition to poverty. People without housing experience more health problems than the rest of the population, such as higher rates of infectious disease (e.g., HIV infection), SUD, mental illness, hypertension, diabetes, and asthma.[13] Homelessness can also exacerbate existing chronic health conditions due to a lack of access to primary and preventive care, in addition to poor living conditions.[14] The homeless population is also more likely to seek care in the ED and be hospitalized than the general population.[15] Feeding America reported that Nevada ranks eighth nationally among states with the highest overall food insecurity in 2021 at 15.2%. The data also reveals that food insecurity in Nevada increased by 24.8% between 2019 and 2021. As part of a Food Security Needs Assessment, Nevada surveyed community members and found that 20% indicated utility bills had an impact on the ability to purchase food every month, and 19% indicated that housing costs made it difficult to purchase food every month.[16]

B. Overview of Nevada's Behavioral Health Delivery System

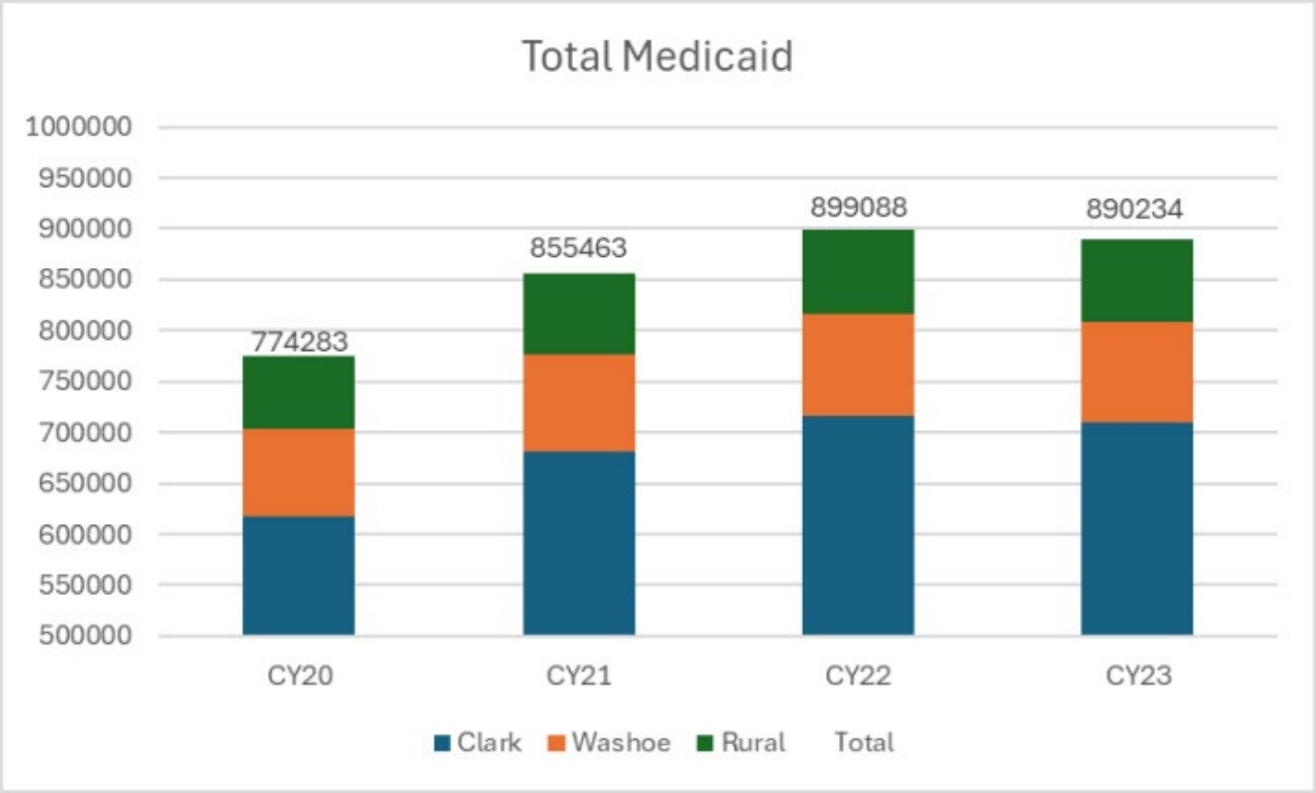
The state of Nevada's Division of Health Care Financing and Policy (DHCFP) Benefits Unit oversees Medicaid policies for rehabilitative mental health, substance abuse prevention and treatment, targeted case management, inpatient hospital psychiatric services, as well as psychiatric residential treatment facilities. Services are delivered via managed care in Clark and Washoe counties, representing approximately 75% of Nevada's population. The majority of the state's population is spread out over rural and frontier areas.[17] The 82nd Legislature authorized the funding of expansion of Medicaid managed care to cover most populations in all counties in Nevada starting with the 2026 managed care organization (MCO) contract.

An estimated 75,000 individuals, including children, parents, and adults without children, who live in rural Nevada counties will be added to managed care. The remaining ~126,000 individuals in the FFS Medicaid program will reflect one of the following groups:

- Katie-Beckett Program for children
- Children in the welfare system (foster care and juvenile justice)
- Individuals with disabilities
- Seniors (ages 65 years and older)
- People receiving home- and community-based waiver services

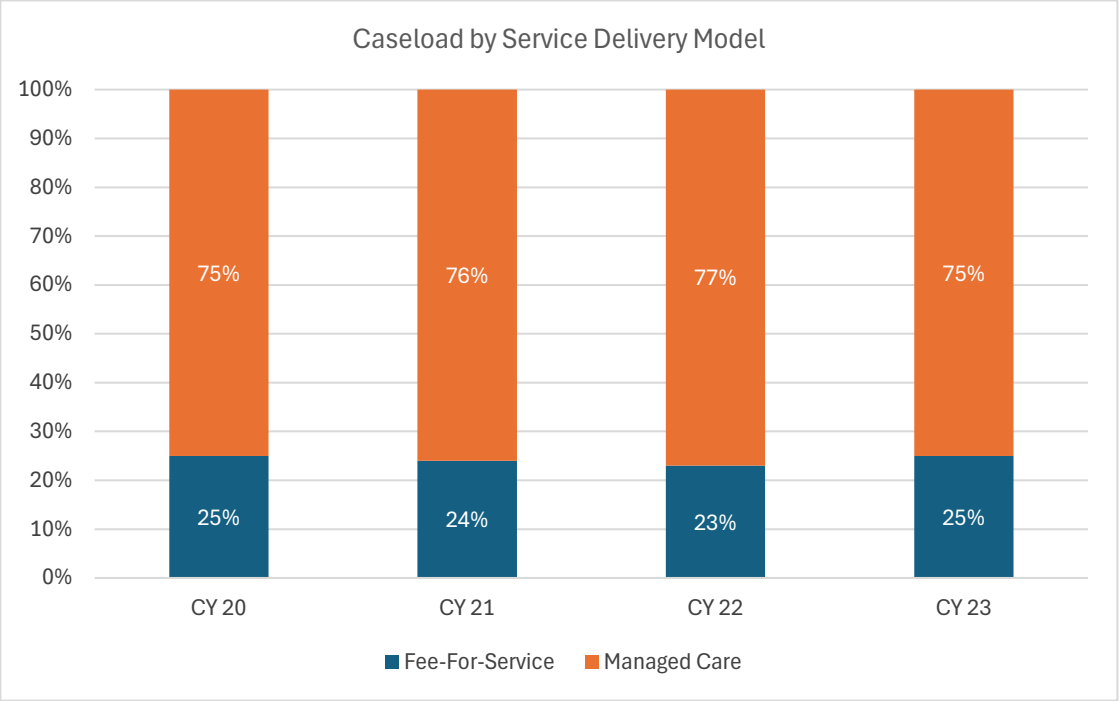
[13] https://www.cdc.gov/phlp/publications/topic/resources/resources-homelessness.html
[14] Health Problems of Homeless People - Homelessness, Health, and Human Needs - NCBI Bookshelf (nih.gov)
[15] Prevalence of Homelessness in the Emergency Department Setting - PMC (nih.gov)
[16] https://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/FINAL_FSSP.pdf

Chart 1: Total Medicaid[18]



[18] 2024 Draft Access to Care Monitoring Review Plan (nv.gov)

Chart 2: Caseload by Service Delivery Model[19]



Additionally, the Nevada Division of Public and Behavioral Health (DPBH) is part of the Department of Health and Human Services (DHHS), under the Executive Branch of the state of Nevada. DPBH is organized into six branches, including the Clinical Services Branch. The primary purpose of the Clinical Services Branch is to provide statewide inpatient, outpatient, and community-based public and BH services to Nevadans. Programs include Lake's Crossing Center for Mentally Disordered Offenders, Northern Nevada Adult Mental Health Services, Southern Nevada Adult Mental Health Services, and Rural Clinics and Community Health Services. Nevada's geographical structure, as well as the rapid growth in Nevada Medicaid, poses challenges in accessing health care. Nevada is made up of 17 counties that include urban, rural, and frontier areas. Due to the rural and frontier nature throughout the state, some recipients must seek medical care outside their residential area.

Nevada Medicaid's philosophy assumes that BH services should be person-centered and/or family driven. This includes ensuring that services are culturally competent, community supportive, and strength based. The services must address multiple domains, be in the least restrictive environment, and involve family members, caregivers, and informal supports when considered appropriate per the recipient or legal guardian. Service providers collaborate and facilitate full participation from team members, including the individual and their family, to address the quality and progress of the individualized care plan and tailor services to meet the recipient's needs. Currently, the State offers an array of BH community and crisis services for children and adults. Nevada also covers services in an IMD under 1115 Demonstration authority since January 1, 2023. Adding the SMI/SED IMD exclusion and HRSN services to the existing SUD

[19] 2024 Draft Access to Care Monitoring Review Plan (nv.gov)

1115 Demonstration will further allow for the Nevada system to fully meet the needs of Medicaid and CHIP members across a continuum of care.

Community-Based Mental Health Services

Children

For children's services, Nevada utilizes the Child and Adolescent Service Intensity Instrument (CASII) to determine intensity of need. The services must be recommended by a physician or other licensed practitioner of the healing arts, within their scope of practice under State law, for the maximum reduction of a physical or mental disability, and to restore the individual to the best possible functioning level. Providers shall deliver youth-guided effective, comprehensive, evidence-based treatments and interventions, monitor child/family outcomes through utilization of child and family team meetings, and continuously work to improve services to ensure overall fidelity of recipient care. A written individualized treatment plan, referred to as the treatment plan, is a comprehensive, progressive, personalized plan that includes all prescribed BH services.

Other services include medication management and medication training and support. For individuals requiring a higher level of care, options include the Partial Hospitalization Program (PHP) as well as mental health intensive outpatient (IOP). The State also has secure 24-hour services, with psychiatric monitoring based on intensity of need. Psychosocial rehabilitation and basic skills training are also provided to both children and adults. These are interventions designed to reduce cognitive and behavioral impairments, restore recipients to their highest level of functioning, and includes self-care, social, and communication skills.

Additional resources are being considered for development for the child mental health system. These include:

- Coverage of qualified residential treatment program-like models with less than 15 beds:
  - Children with serious emotional disturbance (SED)/SMI, who are 13 years to 20 years of age
  - Group home settings (most under 16 beds)

- Expansion of school health services, statewide:
  - Incentivize screening for BH conditions
  - Remove county share individual and family therapy rate increases
  - Add-on for services in rural areas
  - Add-on for in-home services or telehealth in-home for rural behavioral support services and psychosocial

- Rehabilitation services:
  - Rate increases and expansion to all children with SED
  - Rate parity for inpatient psych with acute hospital for psych and detox[20]

Adult

Adult intensity of need is measured via the Level of Care Utilization Scale (LOCUS). The service array

[20] Public Workshop CBHT Presentation 3/21/24 (nv.gov)

currently consists of outpatient mental health (MH) services, rehabilitation mental health (RMH) services, basic skills training (BST), the Program for Assertive Community Treatment (PACT), peer-to-peer services, crisis intervention services, mobile crisis response delivered by designated mobile crisis team, and psychosocial rehabilitation (PSR).

Outpatient MH services employ several different service delivery models: behavioral health community networks (BHCNs), independently licensed BH professionals, and BH rehabilitative treatment providers. Services provided by outpatient MH can include assessment and diagnosis, testing, basic medical and therapeutic services, crisis intervention, MH therapist and therapeutic interventions (PHP and IOP), medication management, medication training/support, and case management services.

BHCNs are public or private entities that provide outpatient MH services (i.e., assessments, therapy, testing, and medication management), 24-hour per day emergency response for recipients, and screening for recipients under consideration for admission to inpatient facilities. There is a requirement that BHCNs coordinate care with individual RMH providers. BHCNs are able to provide PHP when working in collaboration with a hospital or federally qualified health center (FQHC.) Additionally, a FQHC may also provide PHP. BHCNs may also provide IOP.

Independent BH professionals include independently licensed psychiatrists, psychologists, advanced practice registered nurses, physician assistants, licensed clinical social workers, licensed marriage and family therapists, and licensed clinical professional counselors independently licensed in the state of Nevada. Qualified mental health professionals include licensed intern BH professionals, including a Master Social Work (LMSW), Licensed Marriage and Family Therapist Intern (LMFT-I), Licensed Clinical Professional Counselor Intern (LCPC-I).

BH rehabilitative treatment is provided by individual RMH providers and must work under the supervision of an independently licensed BH professional, unless the RMH provider is also enrolled as a qualified MH professional.

BST services are interventions designed to reduce cognitive and behavioral impairments and restore recipients to their highest level of functioning. BST services are provided to recipients with age and developmentally inappropriate cognitive and behavioral skills. BST services help recipients acquire (relearn) constructive cognitive and behavioral skills through positive reinforcement, modeling, operant conditioning, and other training techniques.

PACT is an evidence-based, multi-disciplinary, team-based approach of the direct delivering of comprehensive and flexible treatment, support, and services within the community. PACT is for individuals who have the most serious and intractable symptoms of a severe mental illness and who, consequently, have the greatest difficulty with basic daily activities, keeping themselves safe, caring for their basic physical needs or maintaining a safe and affordable place to live and require interventions that have not been effectively addressed by traditional, less intensive services.

Peer-to-peer support services are interventions designed to reduce social and behavioral impairments and restore recipients to their highest level of functioning. Peer-to-peer supporters (e.g., peer supporters) help the recipient live, work, learn, and participate fully in their communities. Peer-to-peer services must be delivered directly to recipients and must directly contribute to the restoration of the recipient's diagnosed MH and/or BH condition.

PSR services are interventions designed to reduce psychosocial dysfunction (i.e., interpersonal cognitive, behavioral development, etc.) and restore recipients to their highest level of functioning. PSR services target psychological functioning within a variety of social settings.

All adult mental health services require the completion of a comprehensive mental health assessment, to include the diagnosis of a mental or emotional disorder and document a current International Classification of Diseases (ICD) diagnosis, a level of care determination using tools required by Nevada Medicaid (including LOCUS and service-specific assessment tools), and development of a treatment plan that includes measurable goals, objectives, and discharge criteria.

CCBHCs

In addition to the range of BH services for children and adults, the State also has Certified Community Behavioral Health Centers (CCBHCs) that serve any individual in need of care, regardless of ability to pay. The CCBHCs serve the 'whole person' by offering person-centered and family-centered care to:

- Adults with SMI
- Children with SED
- Individuals with severe SUDs
- Individuals with mild or moderate mental illness and substance abuse disorders

CCBHCs provide outpatient BH services and primary care screenings and monitoring for children, adults, and families, with the goals to provide:

- Community-based MH and SUD services
- Combined BH and physical health care, with no wrong-door entry to services
- Evidence-based practices
- Improved access to high-quality care
- Care coordination and case management to address all needs of the individual
- Better overall health outcomes

There are nine CCBHCs providing services under the State Plan authority. CCBHC certification indicates that the entity meets criteria as established by the state of Nevada, by the DPBH Health Care Quality and Compliance (HCQC) Bureau.

Care Management and Care Coordination

Treatment plans should be developed with a goal that promotes collaboration between other health providers of the recipient community supports including, but not limited to, community resources, friends, family, or other supporters of the recipient, and recipient-identified stakeholders, to ensure the recipient can receive care coordination and continuity of care. When multiple providers are involved, a primary care coordinator must be designated. The primary care coordinator develops the care coordination plan between the identified BH services and integration of other supportive services involved with a recipient's services.

Crisis Intervention

Nevada utilized Section 9813 of the American Rescue Plan Act (ARPA) to initiate a state planning grant by CMS to assist in the development and implementation of qualifying community-based mobile crisis

intervention services under its Medicaid State Plan. Due to the planning grant, Nevada identified a need for mobile crisis response teams that comply with ARPA and the US Social Security Administration as designated mobile crisis teams (DMCTs), which the State is planning to implement and develop as a provider model. DMCTs respond in person at the location in the community where a crisis arises or at a family's location of choice. For individuals 18 years of age and younger, responses in urban Clark and Washoe counties are required to be conducted face-to-face and in person, with an average response time within one hour; average response times for these individuals in rural areas are within two hours. Telehealth responses in these locations shall be initiated as soon as possible, within one hour, with face--to-face and in-person team members arriving within one hour in urban areas and within two hours in rural areas. Nevada DHCFP has submitted a State Plan Amendment pending CMS approval for intensive crisis stabilization services performed in a crisis stabilization center endorsed under a hospital licensure.

IMD Facility Capacity

The only public psychiatric hospital serving northern Nevada, Dini-Townsend Hospital, offers acute crisis stabilization on the Rapid Stabilization Unit. This unit has 10 beds. An additional 20 beds are open for acute medical stabilization for individuals that need more intensive therapy. This unit has an average length of stay of 14 days.

Southern Nevada adult MH services are provided for adults living in Clark County. The main campus is located in Las Vegas and has three hospital buildings for the general population as well as a forensic unit. The campus is co-located with the State hospital for children and adolescents.

Lake's Crossing Center (LCC) is a maximum security, forensic psychiatric facility. The program provides inpatient and outpatient services statewide to individuals involved with the criminal justice system and who have concurrent MH issues. The majority of the population served are individuals for whom the question of competency to stand trial has been raised and who may need restoration to competency so they can proceed with their adjudication. Hundreds of outpatient evaluations are performed by the clinical staff annually to determine whether individuals referred by the courts need to be committed for restoration. LCC performs precommitment evaluations for the State, except for Clark County, which contracts with private providers. When a need for restoration is determined, defendants are committed to LCC. Hundreds of defendants a year are provided these inpatient services. The program also treats individuals who are found not guilty by reason of insanity and those who cannot be restored to competency and are assessed as needing the level of care of a maximum-security facility.

Additional inpatient psychiatric facilities are listed below:

Table 2: Inpatient Psychiatric Hospitals

Name	**City**	**Beds**
Desert Parkway Behavioral Healthcare Hospital	Las Vegas	152
Desert Winds Hospital	Las Vegas	114
Reno Behavioral Healthcare Hospital LLC	Reno	103
Seven Hills Hospital, LLC	Henderson	134

Name	City	Beds
Southern Hills Hospital and Medical Center	Las Vegas	265
Desert Willow (state of Nevada)	Las Vegas	30
Southern Nevada Adult Mental Health Services (state of Nevada)	Las Vegas	274
Northern Nevada Adult Mental Health Services (state of Nevada)	Sparks	
Spring Mountain Treatment Center (UHS of Spring Mountain, Inc)	Las Vegas	110
UHS Sahara Inc	Las Vegas	30

HRSN Services

Nevada currently offers housing and nutrition supports under the MCO in-lieu of services (ILOS) authority for managed care members experiencing or at risk of homelessness. These services are optional to the MCOs and members, and the ILOS authority is not applicable to FFS members. Nevada will use a combination of ILOS and this 1115 demonstration authority to promote coverage and access across managed care and FFS.

C. Current Demonstration

CMS approved "Nevada's Treatment of Opioid Use Disorders (OUDs) and Substance Use Disorders (SUDs) Transformation Project" Section 1115(a) Medicaid demonstration on December 29, 2022, for the period from January 1, 2023 through December 31, 2027. Nevada's Health Information Technology and Implementation Plans were approved by CMS on May 24, 2023. The SUD demonstration waiver is focused on services for those with OUDs and other SUDs. The current demonstration waiver allows for payment for services in an IMD for individuals with OUDs and SUDs and increases the State's alignment with the American Society of Addiction Medicine (ASAM) criteria for assessment and levels of treatment for substance use.

Section 3: Proposed Demonstration Amendment

A. Reimburse for Acute Inpatient Stays in IMDs

Nevada Medicaid seeks authority to cover acute inpatient stays in IMDs for Medicaid-eligible individuals ages 21 years–64 years with SMI/SED, including treatment rendered at State psychiatric hospitals. This request is pursuant to legislation passed during the State's 81st Legislative session, and the opportunity was announced by CMS via State Medicaid Director Letter #18-011. Implementation will ensure

alignment with CMS' expectation of the State to achieve a statewide average length of stay of 30 days for beneficiaries receiving care in IMDs.

In addition, through coverage for CHIP enrollees, this demonstration will provide access to essential healthcare for children who are diagnosed with an SED and require treatment in an IMD, and who would otherwise be ineligible for services under Medicaid or for enrollment in CHIP.

B. Implement HRSN Services to Address Housing Needs

Nevada Medicaid seeks to improve health outcomes and lower health care costs by assisting Medicaid recipients with accessing and maintaining stable housing and nutrition supports. Below are the proposed services, populations, and examples of social risk factors and clinical criteria under consideration. ILOS authority will remain in place for MCOs to offer nutrition supports, therefore the nutrition supports included in this request are targeted to FFS members to provide coverage for eligible FFS members consistent with ILOS coverage for managed care members.

Table 3: Proposed Health Related Social Need Services

Service	Definition and Scope	Eligible Population	Social Risk Factors	Clinical Criteria
Housing Navigation and Tenancy Sustaining Services	• Housing transition and navigation services • Pre-tenancy navigation services • Tenancy and sustaining services, including individualized case management • Connecting enrollees to resources to address barriers. For example: o Address denials of health benefits, food stamps, disability benefits o Assist with criminal	All managed care and FFS Medicaid members based on social and clinical criteria	• Homeless OR • At risk of homelessness, with income below 30% of median family income	• SUD/OUD • SMI/SED • At risk of institutionalization or overdose, or in need of residential services because of a SUD, SED, SMI, or other BH condition • At risk of experiencing a BH crisis or utilizing the ED • Pregnant or had a recent live birth within the last sixty (60) days • Discharged from a correctional or medical facility within the last ninety (90) days

Service	Definition and Scope	Eligible Population	Social Risk Factors	Clinical Criteria
	background checks o Prevent evictions o Support access to legal aid			• Transitioning, or will be transitioning, within the next thirty (30) days from an institutional or inpatient setting to the home or community setting OR • Victim of human trafficking or domestic violence
Nutrition and Meal Supports	• Nutrition counseling and instruction, tailored to health risk, nutrition-sensitive health conditions, and/or demonstrated outcome improvement • Home-delivered meals or pantry stocking, up to 3 meals per day	All FFS Medicaid members based on social and clinical criteria	• Homeless OR • At risk of homelessness, with income below 30% of median family income	• SUD/OUD • SMI/SED • At risk of institutionalization or overdose, or in need of residential services because of a SUD, SED, SMI, or other BH condition • At risk of experiencing a BH crisis or utilizing the ED • Pregnant or had a recent live birth within the last sixty (60) days • Discharged from a correctional or medical facility within the last ninety (90) days • Transitioning, or will be transitioning, within the next thirty

Service	Definition and Scope	Eligible Population	Social Risk Factors	Clinical Criteria
				(30) days, from an institutional or inpatient setting to the home or community setting OR • Victim of human trafficking or domestic violence

Section 4: Demonstration Goals and Objectives

The demonstration's overarching objectives have been revised to reflect the proposed inclusion of SMI/SED IMD and HRSN services as outlined below:

1. Increase access to critical SUD and SMI/SED treatment through funding within the Nevada Medicaid program under this demonstration. Amending the demonstration to include SMI/SED services will ensure Medicaid beneficiaries receive the appropriate treatment when determined to need either an ASAM residential/inpatient or a SMI/SED inpatient level of care within an IMD.
2. Enhance the Medicaid delivery system to support the whole person, including physical health, behavioral health, and HRSN services. Housing navigation and tenancy-sustaining services and nutrition supports will ensure Medicaid members in need of stable housing and nutrition receive the necessary supports.
3. Support disenfranchised Medicaid members by promoting equitable access to services and supports. SMI/SED and HRSN services will support some of the most vulnerable Medicaid members.

Section 5: Hypotheses and Evaluation Plan

The State's goals in amending the demonstration are in alignment with CMS' guidance for SMI/SED and HRSN demonstration opportunities, including but not limited to the following:

- Reduced utilization and lengths of stay in EDs among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings
- Reduced preventable readmissions to acute care hospitals and residential settings

- Improved availability of crisis stabilization services, including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state
- Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED, including through increased integration of primary and BH care
- Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals
- Improved capacity and systems for engaging members and identifying needs, including HRSNs
- Improved health status of Medicaid beneficiaries by removing social barriers to health

Based on the identified goals, and in alignment with CMS guidance for SMI/SED and HRSN services demonstrations, the State proposes to test the demonstration under the tentative hypotheses summarized in Table 4 below. All components of the tentative plan are subject to change and will be further refined as Nevada works with CMS to develop an evaluation design consistent with the standard terms and conditions.

Table 4: High-Level Evaluation Plan

Objectives (O)	**Goals (G)**	**Proposed Hypotheses (H)**
O.1.Increase access to critical SUD and SMI/SED treatment through funding within the Nevada Medicaid program under this demonstration. Amending the demonstration to include SMI/SED services will ensure Medicaid beneficiaries receive the appropriate treatment when determined to need either an ASAM residential/inpatient or an SMI/SED inpatient level of care within an IMD.	G.1. Reduced utilization and lengths of stay in EDs among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings	H.1. The SMI/SED demonstrations will result in reductions in utilization and length of stay in EDs among Medicaid beneficiaries with SMI/SED while awaiting mental health treatment.
	G.2. Reduced preventable readmissions to acute care hospitals and residential settings	H.2. The SMI/SED demonstration will result in reductions in preventable readmissions to acute care hospitals and residential settings.
	G.3. Improved availability of crisis stabilization services, including services made available through call centers and mobile crisis units, IOP services, as well as services provided during acute short-term stays in residential crisis	H.3. The SMI/SED demonstration will result in improved availability of crisis stabilization services throughout the state.

Objectives (O)	Goals (G)	Proposed Hypotheses (H)
	stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state	
O.2. Enhance the Medicaid delivery system to support the whole person, including physical health, behavioral health, and HRSNs. Housing navigation and tenancy sustaining services and nutrition supports will ensure Medicaid members in need of stable housing and nutrition receive the necessary supports.	G.4. Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED, including through increased integration of primary and BH care	H.4. Access of beneficiaries with SMI/SED to community-based services to address their chronic mental health care needs will improve under the demonstration, including through increased integration of primary and behavioral health care.
O.3. Support disenfranchised Medicaid members by promoting equitable access to services and supports. SMI/SEDand HRSN services will support some of the most vulnerable Medicaid members.	G.5. Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities	H.5. The SMI/SED demonstration will result in improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.
	G.6. Improved capacity and systems for engaging members and identifying needs, including HRSNs	G.6 Screening for social needs will increase which will result in increased referrals to services over the period of the demonstration.
	G.7. Improved health status of Medicaid beneficiaries by removing social barriers to health	H.7.a. Utilization of preventive and routine care will increase among individuals who receive housing and nutrition supports
		H.7.b. The demonstration will increase access to services and will result in a decrease in avoidable ED use.

The State will provide updates to existing demonstration reporting and quality and evaluation plans. This

will include a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

Data collected to track progress towards the goals and objectives identified above will likely be drawn from a variety of sources, including but not limited to:

- Claims/encounter data
- State eligibility and enrollment data
- Provider enrollment records
- Key informant interviews and focus groups
- Administrative program data
- National and regional benchmarks
- Housing data
- Nutritional supports data

Section 6: Impact on Eligibility, Enrollment, Benefits, Cost Sharing, and Delivery System

A. Eligibility

All mandatory and optional eligibility groups approved for full benefit coverage under the Nevada Medicaid and CHIP State Plans and with a diagnosed SMI/SED requiring an acute, inpatient level of care, would be eligible for short-term stays up to 30 days in an IMD under this demonstration.

All mandatory and optional eligibility groups approved for full benefit coverage under the Nevada Medicaid and CHIP State Plans and meeting the HRSN services eligibility criteria would be eligible for housing navigation and tenancy sustaining services and/or nutrition and meal supports.

B. Enrollment

Nevada is not proposing any changes to Medicaid eligibility policies through this demonstration and, therefore, does not anticipate any impact on enrollment.

The table below represents preliminary projections of the number of Medicaid enrollees anticipated to be eligible for services under this amendment on an annual basis.

Table 5: Preliminary Projections of the Number of Medicaid Enrollees Anticipated to be Eligible for Services

Proposed Service	**Number of Eligible Members Projected Annually**

SMI/SED IMD (managed care and FFS)	8,000
HRSN Housing Supports (managed care and FFS)	78,000
HRSN Nutrition Supports (FFS Only)	11,000

C. Benefits, Cost Sharing, and Delivery System

No modifications to the current Nevada Medicaid FFS or managed care arrangements are proposed through this Demonstration application. All enrollees will continue to receive services through their current delivery system. Additionally, this amendment does not propose beneficiary cost-sharing requirements to receive the proposed 1115 SMI/SED or HRSN services. The amendment does not impact traditional state plan cost-sharing requirements, if any, for any enrollees.

Section 7: SMI/SED IMD Demonstration Implementation

Nevada's strategies for addressing the required SMI/SED IMD demonstration milestones are outlined below.

Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals

Milestone Criteria	**Current State**	**Future State**	**Summary of Actions Needed**
1.a. Assurance that participating hospitals and residential settings re-licensed, or otherwise authorized by the State, primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to participating in Medicaid. This is in compliance with the CMS requirement that	The Bureau of HCQC licenses medical and other health facilities in Nevada.[21] Psychiatric residential treatment centers (PRTFs) are licensed by HCQC and accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), the Joint Commission, and the Council of Accreditation (COA®).[22]	Nevada will continue to ensure participating hospitals and residential settings are licensed by HCQC and that PRTFs are licensed by HCQC and accredited by CARF, the Joint Commission, and COA, as well as CMS PRTF certification, for facilities within Nevada or for other out-of-state facilities whose own survey agencies do not perform CMS certification.	Continue with current actions in place.

[21] https://dpbh.nv.gov/About/Overview/Health_Facilities_Overview/
[22] https://dcfs.nv.gov/Programs/CMH/Resident-day-treatment-svcs/

Milestone Criteria	Current State	Future State	Summary of Actions Needed
the State or local agency used by the Secretary will be responsible for licensing health institutions, and the State agency responsible for such licensing will supervise the determination of whether institutions and agencies meet the requirements for participation in the Medicaid program.			
1.b. Oversight process (including unannounced visits) to ensure participating hospital and residential settings meet State's licensing or certification and accreditation requirements.	DHHS and its divisions are responsible for monitoring different aspects of the statewide BH system. The DPBH, the Division of Child and Family Services, and the DHCFP all play critical roles in the system. DHHS is responsible for planning, providing, regulating, oversight, training/technical assistance, and financing.[23]	No future actions planned at this time.	Continue with current actions in place.
1.c. Utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay.	The utilization review process for an inpatient admission includes certification by the QIO-like vendor, currently Gainwell, within five days of admission. Initial authorizations and reauthorizations are based on medical necessity, clear evidence of a	No future actions planned at this time.	Continue with current actions in place.

[23] https://www.leg.state.nv.us/App/NELIS/REL/81st2021/ExhibitDocument/OpenExhibitDocument?exhibitId=46838&fileDownloadName=0210_DHHS_behavioralhealth_pres.pdf

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	physician's admission order, and the evidence of the recipient meeting the level of care. For children and adolescents, this includes meeting the CASII criteria for Level VI, and for adults, a LOCUS score of VI. The QIO-like vendor will take into account any details as to why an inpatient level of care is needed if the score is below a VI on either tool as they review the prior authorization request. HCQC does do unannounced visits. CMS is also able to conduct visits of certified facilities as indicated.		
1.d. Compliance with program integrity requirements and State compliance assurance process.	The program that protects the integrity of Nevada Medicaid from provider fraud, waste, abuse, and improper payments is known as the Surveillance and Utilization Review (SUR) Unit. The SUR unit identifies aberrant billing practices, educates those who have improperly billed the Medicaid program, recovers overpayments, recommends sanctions for those who abusively bill Medicaid, and assists in criminal	CMS conducts State program integrity reviews to assess the effectiveness of the State's program integrity efforts, including its compliance with federal statutory and regulatory requirements. The reviews also assist in identifying effective State program integrity activities and sharing best practices with other states. As a result of recent desk reviews, several states have acknowledged the need to increase their audit	Nevada will continue to explore implementation of a unified program integrity contractor.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	investigations when appropriate. The SUR unit performs a variety of other functions such as detecting areas in which Medicaid regulations, policy, and/or system edits may be modified, and administering the provisions of the False Claims Act.[24] The Medicaid Fraud Control Unit additionally investigates and prosecutes Medicaid provider fraud and patient abuse or neglect in medical facilities.[25] Medicaid provider enrollment also performs credentialing and background checks before a provider may even enroll.[26]	activity and have engaged with the unified program integrity contractors to develop projects to address this weakness.	
1.e. State requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions.	The medical record is required to contain an initial assessment of the recipient's clinically identifiable psychiatric disorder, which should include a chief complaint or equivalent, a history of the disorder, a statement of the circumstances that led to the request for services, a mental status examination and observations, a diagnosis or differential	Nevada will update the Medicaid Service Manual (MSM) to require all psychiatric hospitals, residential settings, and PRTFs, to complete screening for co-morbid physical health, SUDs, and suicidal ideation.	The Inpatient Mental Health Services Policy in the MSM will be updated within the first 90 days of demonstration approval. Existing residential policies in the MSM will be updated within the first 90 days of demonstration approval. New policies for

[24] https://dhcfp.nv.gov/Resources/PI/SURMain/
[25] Medicaid Fraud Control Unit (nv.gov)
[26] Medicaid Fraud Control Unit (nv.gov)

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	diagnosis, and a statement of treatment goals and objectives and method of treatment. This assessment should include co-morbid conditions as well as suicidal ideation.[27] In accordance with CMS conditions of participation and Joint Commission standards, all hospitals are required to utilize evidence-based suicide assessment tools and must complete a physical exam within 24 hours of an individual's admission.		residential treatment will include the requirement that beneficiaries are screened for co-morbid physical health, SUD, and suicidal ideation.
1.f. Other State requirements/policies to ensure good quality of care in inpatient and residential treatment settings.	PRTFs are required to have an effective, comprehensive quality improvement program to evaluate the provision of care to its residents. The program must have a committee to oversee the plan and the quality of the program and document appropriate remedial action to address deficiencies found through the quality improvement program. The outcome of remedial actions and ongoing quality outcomes are to be	Nevada is planning to implement new strategies to improve the quality of services in PRTFs, with a targeted date of January 1, 2025. Strategies include: • A new flat base rate of $800 for all PRTFs. • Add on of $100 for children under the age of 9 years. • Add on of $100 for children with complex needs. • Develop new quality bonus payment for PRTFs tied to robust discharge planning, shortened lengths of stay, and successful	Seek State approval from the State's Interim Legislative Finance Committee. Seek federal State Plan amendment approval.

[27] MSM Chapter 400, Section 403.9B(2)

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	monitored and evaluated by the committee.[28]	community transitions and low readmissions. • Facilities will be required to obtain federal certification as a PRTF. • Nevada will increase monitoring and transparency of data and quality metric performance.[29] Nevada will also be amending the rate methodology for inpatient psychiatric facilities. Currently, rates are negotiated by facility but will transition to a flat rate that is in parity with hospitals that have psychiatric units.	

Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care

Milestone Criteria	Current State	Future State	Summary of Actions Needed
2.a. Actions to ensure psychiatric hospitals and residential settings carry out intensive predischarge planning, and include community-based providers in care transitions.	Psychiatric residential treatment facilities are required to have a process for developing and carrying out discharge planning for all residents in a manner that does not contribute to delays in the discharge of the resident. An evaluation of the needs of the resident pertaining to	CCBHCs and PRTFs in Nevada are working together to improve the transition to the community process. In addition, Nevada Medicaid is planning to implement high-fidelity wraparound, an individualized, team-based, collaborative process to provide a	The State plans to obtain authority to spend up to 15% of revenue from the State's private hospital tax to finance new services and enhancements for children's BH care. Nevada will then need to work with the Legislative Interim Finance Committee for

[28] NAC 449.424 Quality improvement program.
[29] Public Workshop CBHT Presentation 3/21/24 (nv.gov)

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	discharge should be documented in their record and discussed with the resident or person acting on their behalf.[30] In addition, every medical facility and facility for the dependent must provide the services necessary to properly treat a patient or arrange the transfer of the patient to another facility which can provide that care. A patient may be transferred to another facility only if the patient has received an explanation of the need to transfer the patient and the alternatives available, unless the condition of the patient necessitates an immediate transfer to a facility for a higher level of care, and the patient is unable to understand the explanation.[31]	coordinated set of services and supports for children and youth with complex emotional, behavioral, or mental health needs, and their families. A care coordinator will convene, facilitate, and coordinate efforts of the wraparound team and help the family navigate planned services and supports, including informal and community-based options and will track progress, making revisions to the treatment plan as indicated.[32]	additional funding authority and then begin seeking State and federal authorities for new services. There will be a ramp-up period for the State to integrate new services and enhancements and changes to the delivery system.
2.b. Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed	Housing supports and services are currently available as an in lieu of service to individuals who are transitioning or will be transitioning within the next thirty	Nevada will add the requirement to the MSM that psychiatric hospitals and residential settings assess a beneficiary's housing	Updates will be made to the Nevada MSM, to include a review of the biopsychosocial assessment requirements as it relates to housing

[30] https://casetext.com/regulation/nevada-administrative-code/chapter-449-medical-and-other-related-facilities/psychiatric-residential-treatment-facilities/provision-of-services/section-4494495-discharge-planning
[31] https://www.leg.state.nv.us/NRS/NRS-449A.html#NRS449ASec100
[32] Public Workshop CBHT Presentation 3/21/24 (nv.gov)

Milestone Criteria	Current State	Future State	Summary of Actions Needed
and available.	(30) days from an institutional or inpatient setting to the home or community setting.	situation at admission and prior to discharge. Psychiatric hospitals and residential providers will coordinate with housing resources and housing service providers, where available, when a beneficiary has unmet housing needs.	situation assessment.
2.c. State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers through the most effective means possible (e.g., email, text, or phone call) within 72 hours post discharge.	This is not a current documented requirement for Nevada's psychiatric hospitals and residential settings.	Nevada will add a requirement to the MSM that psychiatric hospitals and residential providers must contact beneficiaries within 72 hours of discharge via the most effective means possible (e.g. email, text, or phone call).	The Nevada MSM will be updated.
2.d. Strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED prior to admission.	Crisis stabilization centers are triage and assessment, short-term psychiatric stabilization, and/or medical detoxification services. They are available 24/7, with most individuals deemed stable and safe for discharge to resources in their community within 23 hours. Community support services are offered on-site, including linkage to Medicaid enrollment, case management, primary care, outpatient therapy, and housing.	Plans include developing crisis and planned respite for youth with SED and youth in foster care.[33]	The State plans to obtain authority to spend up to 15% of revenue from the State's private hospital tax to finance new services and enhancements for children's BH care. Nevada will then need to work with the Legislative Interim Finance Committee for additional funding authority and then begin seeking State and federal authorities for new services. There will be a ramp-up

[33] Public Workshop CBHT Presentation 3/21/24 (nv.gov)

Milestone Criteria	Current State	Future State	Summary of Actions Needed
			period for the State to integrate new services and enhancements and changes to the delivery system.
2.e, Other State requirements/policies to improve care coordination and connections to community-based care	Case management services are provided to eligible recipients residing in a community setting or transitioning to one after an institutional stay. Two of the nine target groups eligible for case management services are adolescents who are SED and adults who are SMI. Transitional targeted case management services are provided to eligible recipients transitioning to a community setting after a period of time in a psychiatric facility or hospital for recipients under the age of 21 years. Transitional targeted case management services are provided 14 days prior to discharge for an institutional stay. Transitional targeted case management activities are coordinated with, and are not a duplication of, institutional discharge planning services. When multiple providers are involved, the plan	Nevada is considering a Collaborative Care Model, in which a team of healthcare providers works together to address the physical and mental health needs of a patient. The team would foster communication and coordination between primary care providers, mental health specialists, and other healthcare professionals. This allows primary care to do assessments and screening, and then refer and stay in communication, and coordinate care with more specialized mental health treatment and support.	A public hearing is scheduled for discussion on the Collaborative Care Model on July 30. The State will continue to gather feedback to design and implement a Collaborative Care Model for Nevada Medicaid.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	must identify and designate a primary care coordinator. The primary care coordinator develops the care coordination plan between the identified BH services and integration of other supportive services involved with a recipient's services.[34]		

Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services

Milestone Criteria	Current State	Future State	Summary of Actions Needed
3.a. The State's strategy to conduct annual assessments of the availability of mental health providers, including psychiatrists, other practitioners, outpatient, community mental health centers, intensive outpatient/partial hospitalization, residential, inpatient, crisis stabilization services, and FQHCs offering mental health services across the state, updating the initial assessment of the availability of mental health services submitted with the State's demonstration application. The content of annual assessments should be reported in the State's	Nevada currently contracts with MCOs to provide the following Medicaid-funded services: outpatient MH services, RMH services, BST services, PACT, peer--to-peer services, PSR services, crisis intervention services, mobile crisis response delivered by a designated mobile crisis team, crisis stabilization center, PRTF services (under age 21 years only), and inpatient mental health services. Nevada also has 45 FQHCs and 18 rural health clinics. Nevada DHHS's Office of	DHCFP's Quality Access and Availability Unit will continue to monitor FFS MH provider availability quarterly, as well as annually, in a way that aligns with the CMS requirements detailed in the 1115 demonstration instructions. The next quarter's report will include additional demographics as part of an effort to review for any disconnects and need for increased outreach for specific populations to ensure quality and equity.	Continue to review quarterly and annual access and availability assessments. Update current reports with additional demographics to increase quality and equity of services.

[34] https://aspe.hhs.gov/sites/default/files/2021-08/StateBHCond-Nevada.pdf

Milestone Criteria	Current State	Future State	Summary of Actions Needed
annual demonstration monitoring reports.	Analytics collects data from several different sources across the department for a variety of reports, including provider access and availability. Reports include both billing, as well as enrolled providers, to review which providers are actually providing services, as well as both eligible members and members utilizing services. DHCFP's Quality Access and Availability Unit reviews information and works with other areas of DHHS to determine ways to outreach and enroll providers, addressing areas such as provision of services in rural areas. Interventions may include payment increases for certain provider types and other avenues to close provider gaps. Reports for managed care providers are also reviewed to ensure adequate network coverage and planned MCO interventions to address areas of concern.		
3.b. Financing plan	The State recognizes the requirement to maintain a level of State and local funding for outpatient community-based mental health services for Medicaid beneficiaries for the duration of the	Nevada will continue building services, such as its Intensive Crisis Stabilization Services, and expand its crisis bed tracking system as well as continue efforts to increase community-	Nevada will submit a detailed financing plan at demonstration approval. For children's services, the State plans to obtain authority to spend up to 15% of revenue from the

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	SMI/SED program under the demonstration that is no less than the amount of funding provided at the beginning of the SMI/SED program under the demonstration.	based collaboration such as exploration of the Collaborative Care Model.	State's private hospital tax to finance new services and enhancements for children's BH care.
3.c. Strategies to improve State tracking of availability of inpatient and crisis stabilization beds.	Nevada is currently using Open Beds to track availability of inpatient and crisis beds. The platform works to facilitate the following processes: • Identification of appropriate placement based upon initial assessment using ASAM criteria • Enhancement of patient care through real-time referral • Streamlined and standardized electronic referral processes that capture real-time response and use shared definitions • Transparency between providers • Capture of data specific to level of care, services, and continuums of care	Nevada will explore inpatient and crisis bed-tracking platforms that meet the standards identified by CMS Section 9813 of ARPA. If possible, Nevada will ensure that the tracking platform is accessible to mobile crisis management teams and crisis intervention services to support rapid coordination with crisis and inpatient beds. An RFI was issued in April 2023, as a precursor to an RFP in summer 2023, for Nevada's Behavioral Health Crisis Care Hub to help gather information on services, workforce, technology, and cost to inform the RFP.[35] Nevada will revise existing policies to require that all psychiatric hospitals and residential treatment programs submit data to ensure accurate and up--to-date tracking of inpatient and crisis stabilization beds.	Nevada will issue an RFP for a Behavioral Health Crisis Care Hub. Once a vendor is selected, Nevada will use the tracking platform to increase accessibility to rapid coordination of available crisis support services.
3.d. State requirement that	Per the MSM, all	Continued State	Continue with current

[35] Production of Nevada - Bid Solicitation (nevadaepro.com)

Milestone Criteria	Current State	Future State	Summary of Actions Needed
providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay.	comprehensive assessments must evaluate the recipient's history and current state, including a functioning, current ICD diagnosis and summary of rehabilitative treatment needs. The assessment should identify psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health needs, to include the biopsychosocial factors important to physical health needs. The Intensity of Needs Determination is defined as a standardized mechanism to determine the intensity of services needed based on the recipient's condition. Currently, the DHCFP recognizes the LOCUS for adults and CASII for children and adolescents. All concurrent review or transition requests are required to include an updated LOCUS or CASII, that either confirms the current level of care is still clinically needed or identifies the next clinically appropriate level of care the individual should transition to.	approval of assessments used for level of care determination.	actions in place.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
3.e. Other State requirements/policies to improve access to a full continuum of care, including crisis stabilization.	Crisis stabilization centers (CSCs) are a part of the crisis continuum of care and were added as a State Plan service as a result of the State's Section 9813 of the ARPA Planning Grant. CSCs are designed to stabilize and improve symptoms of distress. The intensive crisis stabilization services definition covers both the CSCs, which are specific to hospitals with endorsements, as well as allowing for the possibility of a community-based provider. The Mallory Center in Carson City is fully endorsed, with planned sites by Renown in Reno and an additional site in Nevada.	No additional policies currently planned.	Nevada will continue to build its intensive crisis stabilization providers. The State Plan amendment for the daily rate for these providers is pending implementation as it is still under review by CMS.

Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration

Milestone Criteria	Current State	Future State	Summary of Actions Needed
4.a. Strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner (e.g., with supported employment and supported programs).	Nevada currently offers employment services through the Division of Vocational Rehabilitation (DVR), which provides services to any Nevada resident with physical, cognitive, or BH disability. DVR also manages the Ticket to Work benefit, which	Nevada will implement at least one individual placement and support (IPS) team and will develop an IPS policy and a rate. Nevada will either provide or make arrangements for training and technical assistance to ensure the IPS team adheres	Nevada has begun to work with its vocational rehabilitation partners to develop an IPS-SE policy and workforce. Combined efforts between the two agencies will continue.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	allows residents that receive SSI or SSDI benefits to explore work options without the risk of losing benefits until they have stabilized their job and earnings. There currently are no Medicaid-funded, supported employment programs, and no evidence-based practices for supported employment services with individuals diagnosed with SMI or SED being used in the state.	to evidence-based practices. Nevada will require that all BH assessments assess a beneficiary's employment and/or education resources and needs and that providers directly link beneficiaries to either an IPS team (when available) or to the regional vocational rehabilitation office. Nevada will develop IPS policy guidance that requires IPS teams to have a minimum 0.5 FTE employment peer mentor on each IPS team. The employment peer mentor role will include tasks related to outreach and engagement of individuals with SMI or SED, in addition to providing peer mentoring and coaching to individuals receiving IPS. Nevada will require all coordinated specialty care teams to employ a supported education and employment specialist to provide evidence-based education and employment supports to young adults experiencing their first episode of psychosis.	

Milestone Criteria	Current State	Future State	Summary of Actions Needed
4.b. Plan for increasing integration of BH care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment.	School-based child health services are available for eligible Medicaid and Nevada Check Up children between 3 years of age and under the age of 21 years, in both FFS and managed care. Services available include: • Evaluation and testing • Psychological counseling • Nursing services • Therapy services • Crisis intervention services • Physical therapy • Occupational therapy • Speech therapy • Audiology All of these services may assist in integrating BH services in non-specialty settings.[36]	Nevada is exploring implementing the Collaborative Care Model to continue the expansion of non--specialty integrated settings. Nevada will coordinate closely with the Nevada primary care providers. Nevada will review the January 2023 CMS guidance on interprofessional consultation to identify opportunities to improve timely access to specialty care, including BH services. Nevada will explore piloting a coordinated specialty care team to better meet the needs of beneficiaries aged 18 years and younger experiencing their first episode of psychosis, to better meet their emerging treatment needs and more closely coordinate care across multiple healthcare settings.	Implement pilot for coordinated specialty care team for beneficiaries aged 18 years and younger experiencing their first episode of psychosis.
4.c. Establishment of specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI.	Nevada does use crisis stabilization centers as an emergency healthcare alternative, providing persons with an acute BH problem (including co-occurring disorders) with prompt action and	MSM will be updated to include more general providers of intensive crisis stabilization services.	Nevada will continue to build its intensive crisis stabilization providers. The State Plan amendment for the daily rate for these providers is being implemented/is still

[36] MSM Chapter 2800 11/29/23 (nv.gov)

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	effective support in a respectful environment. Crisis stabilization centers are a no-wrong-door access. Crisis stabilization centers are a short-term, subacute care for recipients that support an individual's stabilization and return to active participation in the community. This model is traditionally meant to last 24 hours or less. If recipients cannot be stabilized in this period, the next step would be to refer them to an appropriate level of care at an inpatient facility. Crisis stabilization centers are part of a continuum of crisis services designed to stabilize and improve symptoms of distress. Recipients who can be stabilized in a crisis stabilization center are anticipated to be discharged to a lower level of care. Nevada leveraged a Section 9813 of the ARPA State Planning grant to assist in the development and implementation of qualifying community-based mobile crisis intervention services. Senate Bill 390 encouraged the establishment of mobile		under review by CMS.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	crisis teams to provide community-based intervention, including de-escalation and stabilization.		
4.d. Other State strategies to increase earlier identification/engagement, integration, and specialized programs for young people.	Nevada operates a 1915(i) Home- and Community-Based Services State Plan option for intensive -in-home supports and services, and crisis stabilization services for youth in specialized foster care. Services include intensive -in-home services and supports as well as crisis stabilization services.[37]	Nevada's proposal for enhancing the community BH system for children includes early comprehensive screening and assessment of children for BH needs.	Implement early comprehensive screening and assessment of children for BH needs.

Section 8: Requested Waivers and Expenditure Authority

Below is a preliminary list of expenditure and waiver authorities related to Title XIX and XXI authority that the State believes it will need to operate its demonstration. The State acknowledges that additional authorities may be identified by CMS during the waiver approval process.

- **IMD Expenditure Authority:** for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment for SMI/SED and are short-term residents in facilities that meet the definition of an IMD
- **HRSN Services Expenditure Authority**: for services not otherwise covered that are furnished to individuals who meet the qualifying criteria
- **State-wideness Section 1902(a)(1)**: to the extent necessary, to enable the State to provide HRSN services only in certain geographical areas of the state
- **Amount, Duration, Scope, and Service Section 1902(a)(10)(B)**: to permit the State to provide HRSN services and enhanced SMI/SED services for the populations covered under this demonstration that are not available in the standard State Plan benefit package, including services that may vary based on assessment of needs and delivery system.

[37] MSM 4000 10/27/21 (nv.gov)

Section 9: Financing and Budget Neutrality

A. Budget Neutrality

The State understands that it must demonstrate budget neutrality for the Treatment of Serious Mental Illness (SMI)/Severe Emotional Disturbance (SED) Transformation Project. Budget neutrality for the State's Treatment of Serious Mental Illness (SMI)/Severe Emotional Disturbance (SED) Transformation Project will be demonstrated through the use of the per capita method outlined in the CMS SMI/SED 1115 demonstration budget-neutrality template ("CMS template"). The budget-neutrality projections were developed using CMS requirements, with the format adjusted to accommodate the services outlined in this demonstration request. As discussed above in this application, the State is requesting demonstration authority for the following hypothetical expenditures:

- Expenditures for services furnished to beneficiaries who are residing in an IMD, primarily to receive treatment for a SMI/SED. For the purposes of budget neutrality, this application assumes that services shall be considered hypothetical expenditures and treated as pass-through services. As clarified by CMS guidance, SMI/SED IMD expenditures are deemed as hypothetical, as they would have been otherwise allowable under Medicaid were it not for the IMD/settings prohibition.
- Expenditures for HRSN housing navigation and tenancy sustaining services, and nutrition and meal supports. For the purposes of budget neutrality, this application assumes HRSN services are hypothetical expenditures and treated as pass-through services. As clarified by CMS guidance, states are not required to offset these expenditures with budget neutrality savings and will not be permitted to accrue savings if actual expenditures are lower than expected.

For the purposes of budget neutrality, Nevada calculated the projected total member months and expenditures as follows:

- SMI/SED: Member months are based on any whole month during which a Medicaid-eligible person is an inpatient in an IMD at least one day. The per member per month cost is the average of all medical assistance costs incurred during IMD member months, divided by the estimated IMD member months.
- HRSN Services:
    - Member months are based on a) the projected total number of Medicaid eligible homeless individuals and b) those at-risk of homelessness, with income at or below 30% of the median family income for the state. Member months are adjusted based on budget availability and network capacity to assume a ramp up of services over the course of the demonstration.
    - Projected housing navigation and tenancy costs are informed by estimates of FTEs and standard caseload assumptions for eligible managed care and FFS members.
    - Projected nutrition and meal supports costs include up to three meals per day, for a

maximum of six months, in conjunction with nutrition counseling of three hours per year for eligible FFS members.

As outlined in the table below, the without demonstration and with-demonstration projections result in budget-neutral expenditure projections for the demonstration period.

Table 6: Without and With-Demonstration Projections

Without-Waiver Total Expenditures						Aggregate
	DEMONSTRATION YEARS (DY)					TOTAL
	2023	2024	2025	2026	2027	
SUD IMD Services MEG 1 (MCO)	$5,326,640	$5,611,258	$5,911,073	$6,226,899	$6,559,620	$29,635,490
SUD IMD Services MEG 2 (FFS)	$1,661,036	$1,749,791	$1,843,284	$1,941,769	$2,045,523	$9,241,403
SMI/SED IMD Services MEG 3 (MCO)	$0	$0	$46,695,061	$49,189,950	$51,818,176	$147,703,187
SMI/SED IMD Services MEG 4 (FFS)	$0	$0	$1,130,363	$1,190,758	$1,254,380	$3,575,501
HRSN Services MEG 5	$0	$0	$81,464,443	$128,026,537	$175,214,758	$384,705,737
HRSN Infrastructure MEG 6	$0	$0	$10,686,270	$12,823,525	$12,823,525	$36,333,320
TOTAL	$6,987,676	$7,361,049	$147,730,494	$199,399,438	$249,715,982	$611,194,639
With-Waiver Total Expenditures						
	2023	**2024**	**2025**	**2026**	**2027**	**TOTAL**
SUD IMD Services MEG 1 (MCO)	$5,326,640	$5,611,258	$5,911,073	$6,226,899	$6,559,620	$29,635,490
SUD IMD Services MEG 2 (FFS)	$1,661,036	$1,749,791	$1,843,284	$1,941,769	$2,045,523	$9,241,403
SMI/SED IMD Services MEG 3 (MCO)	$0	$0	$46,695,061	$49,189,950	$51,818,176	$147,703,187
SMI/SED IMD Services MEG 4 (FFS)	$0	$0	$1,130,363	$1,190,758	$1,254,380	$3,575,501
HRSN Services MEG 5	$0	$0	$81,464,443	$128,026,537	$175,214,758	$384,705,737
HRSN Infrastructure MEG 6	$0	$0	$10,686,270	$12,823,525	$12,823,525	$36,333,320
TOTAL	$6,987,676	$7,361,049	$147,730,494	$199,399,438	$249,715,982	$611,194,639
Net Overspend	$0	$0	$0	$0	$0	**$0**

B. Maintenance of Effort

The State recognizes the requirement to maintain a level of State and local funding for outpatient community-based mental health services for Medicaid beneficiaries for the duration of the SMI/SED program under the demonstration that is no less than the amount of funding provided at the beginning of the SMI/SED program under the demonstration. The following table includes the CY 2023 outpatient community-based mental health service expenditures.

Table 7: Outpatient Community-Based Mental Health Maintenance of Effort

Baseline Year	Medicaid Service	Total Computable Expenditures
CY 2023	Outpatient Community-based Mental Health	$483,000,000

Section 10: Public Notice and Tribal Consultation

The State is conducting public notice in accordance with 42 CFR §431.408. A summary of comments received and any applicable demonstration updates in response to comments will be completed pending completion of the public notice periods.

A. Public Comment

The State conducted public comment as follows: PLACEHOLDER

B. Tribal Consultation

The State conducted tribal consultation as follows: PLACEHOLDER