Solicitation of Public Input Regarding the Implementation of a New Specialty Managed Care Plan for Certain Children and Youth Populations

Community Care Health Plan of Nevada, Inc. (Anthem)

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1. Targeted Case Management

1. TARGETED CASE MANAGEMENT

Anthem welcomes the opportunity to share our insight on The Nevada Division of Health Care Financing and Policy's (the Division's) development of a Specialty Managed Care Plan (SMCP) to better support service delivery for Medicaid-eligible children with behavioral health needs. Our goal is to provide care that ensures continuity, quality, and equity in collaboration with community supports already in place. Based on our organization's experience in Washington State and other states, we are excited to offer innovative recommendations for a model that enhances the integration of case management services without disrupting existing local systems.

ASSESSMENT OF THE WASHINGTON STATE HYBRID MODEL

The Washington State hybrid model designates the largest counties as case management providers for the SMCP, enhancing accountability and optimizing funding by directing payments through the SMCP. This approach was intended to streamline operations through a single source payor. It also facilitates greater integration, shared training, and data exchange between local case management teams and the SMCP.

Some components of the Washington State hybrid model could be implemented in Nevada to render integrated case management services in an efficient, cost-effective manner. This model leverages local expertise to ensure care is better integrated and coordinated for Members with both physical and behavioral health conditions. It also streamlines accountability for managing the overall health of Members, including their social needs. However, duplicative billing, risk of fragmented care, and administrative burden pose challenges to long-term sustainability. Feedback from stakeholders highlights the need for a more integrated model to address these issues effectively, and we agree. As the Division transitions toward a managed care model for this population, it is important to build on the foundation of the current system while finding solutions for the existing fiscal and operational challenges.

PROPOSED HYBRID MODEL FOR NEVADA

We support the Division's exploration of a hybrid model that draws inspiration, in part, from Washington State. This approach aims to integrate the SMCP into local systems without losing local expertise and partnerships to ensure a seamless transition for children and families.

The proposed hybrid model allows local entities to maintain their roles through contracting arrangements with the SMCP. This arrangement ensures counties maintain the case management provider role as long as it is contracted with the SMCP — similar to a network provider rendering these services on behalf of the SMCP. For high-needs populations, like foster care youth, these elements are essential for continuity of care.

While a hybrid approach offers multiple benefits — local expertise, integrated behavioral health services, deeper reach into the communities, county retention of risk for Members, and better continuity of care — there are also challenges that must be addressed. These include managing and tracking outcomes for Members and managing care when Members move to different counties to ensure their care is not disrupted. Additionally, because Member data is encounter-based and not claims-based, there are limitations with data sharing and availability. Through

thoughtful collaboration and consideration of best practices and lessons learned, we believe these challenges can be overcome.

BEST PRACTICES AND LESSONS LEARNED

Washington State and other states with similar approaches have successfully implemented hybrid models by contracting with regional agencies for case management while maintaining centralized oversight. This approach has allowed local entities to retain service delivery roles, resulting in improved continuity of care, better outcomes, and greater stakeholder satisfaction. In Washington State's experience, managing incentives through network provider contracts increased local engagement and reduced resistance to the managed care transition.

Key success factors of similar hybrid models include shared training sessions between the SMCP and contracted entities, collaborative and integrated clinical rounds for high-risk Members, shared accountability for performance metrics, bi-directional platforms for clinical documentation and Member data, and interdisciplinary advisory committees. These best practices can be adapted for Nevada's needs, aiming to develop a flexible, collaborative model that effectively manages complex care needs.

RECOMMENDATIONS AND CONSIDERATIONS

We recommend the Division adopt a flexible hybrid model that is standardized in structure while adaptable to reflect Nevada's needs and resources across the state. The SMCP should be able to provide care management services and maintain strong oversight of subcontractors, including Care Management Entities (CMEs), to ensure services as appropriate and effectively meet complex Member needs. Key components of a flexible hybrid model may include:

- Allowing local entities to opt into contracting arrangements with the SMCP to retain established relationships and local resource knowledge
- Implementing financial oversight mechanisms to prevent duplicative billing and ensure financial transparency
- Including contractual measures that support performance monitoring, culturally responsive practices, and capacity-building investments for local partners
- Establishing a strong oversight role maintained by the SMCP to ensure quality and compliance adherence to requirements
- Developing an agreed-upon strategy for transitioning Members between CMEs, including the county-retained system

In summary, our feedback emphasizes the importance of maintaining current, successful practices while integrating aspects of successful models that enhance holistic service delivery. We support a collaborative approach in refining the SMCP model to meet Nevada's needs effectively.

2. Care Management Approach

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2. CARE MANAGEMENT APPROACH

Effective care management is vital to providing quality services to children with behavioral health needs, particularly those at risk for Serious Emotional Disturbance (SED) or Serious Mental Illness (SMI), and foster youth navigating multiple systems. Anthem advocates for an approach based on national best practices, focusing on accessibility, accountability, and holistic treatment.

RECOMMENDED BEST PRACTICES

Care management best practices are centered around integrated care coordination that addresses Members' physical, behavioral, and social needs through comprehensive and age-appropriate screenings, assessments, treatment planning, and interventions. The evidence-based models described below promote an interdisciplinary, child-and family-centered approach to address each youth's unique needs across the continuum of care.

High Fidelity Wraparound (HFW). The HFW model is a comprehensive, family-centered approach designed to support high-risk youth by integrating community resources, fostering stakeholder collaboration, and empowering families to achieve sustainable positive outcomes. It employs a needs and strengths assessment process to identify and leverage the strengths of the youth and family, focusing on goal achievement and enhanced well-being — moving away from traditional, problem-focused models. This family-driven, strength-based model ensures the creation of individualized plans and aims to prevent out-of-home placements.

Integrated Care Management (ICM). ICM across multiple systems is crucial to address the diverse needs of SMCP Members through comprehensive needs assessments, child- and family-centered care coordination, interdisciplinary collaboration, and community integration. The focus on prevention and wellness enhances communication among caregivers, providers, and community agencies in support of Members' complex care needs. This model achieves success by facilitating smoother care transitions, preventing service gaps, and improving continuity of care through child- and family-driven treatment planning.

SUGGESTED APPROACH FOR SMCP IMPLEMENTATION

We recommend a flexible model using a hybrid approach that gives counties the option either to provide care management to Members or have the SMCP both provide care management services and maintain oversight of subcontracted CMEs. This collaboration would ensure continuity of care across all counties and honor the flexibility that will best serve each Member.

This model aligns with the Division's goals to reduce institutional care and expand access to less restrictive community-based services. A subcontracted CME model enables statewide reach and regional responsiveness — ensuring children receive personalized care close to home. To ensure the SMCP and CME providers uphold the highest standards of care, we recommend:

- Establishing credentialing and performance standards for the SMCP and CMEs
- Defining the SMCP's role to include monitoring provider performance and quality of care

To ensure effective care management, the Division may consider these best practices and approaches in the development of an integrated, child- and family-driven model.

3. Benefit Set

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3. BENEFIT SET

Anthem supports the Division's whole-child and whole-family approach through an integrated benefit set that aligns physical, behavioral, and social needs within a single SMCP. This model streamlines care, avoids duplication, and prioritizes early identification and intervention.

INTEGRATED BENEFIT SET

States like Washington have effectively implemented integrated managed care models for Medicaid-eligible children with behavioral health needs — combining services for behavioral and physical health, pharmacy, transportation, and more. This unified approach enhances case management, streamlines prior authorization, and coordinates transitions across levels of care.

For the integrated delivery system, we recommend including:

- Comprehensive behavioral health benefits, including crisis stabilization, intensive in-home therapy, day treatment, family peer support, and respite care
- Physical health, pharmacy, dental, and vision services, as well as timely transportation
- Co-management tools, such as shared treatment plans and integrated health information technology (IT) platforms

This approach will enable the SMCP to wrap services around the child and family — prioritizing stability, resilience, and positive outcomes while ensuring integrated, whole-person care.

VALUE-ADDED BENEFITS

Value-added benefits (VABs) are meaningful services and supports that address Members' holistic needs and drive improved health outcomes. We believe the development of VABs should be a collective effort to ensure VABs offered by the SMCP align with the Division's priorities and effectively address the diverse needs of Members. The most impactful VABs are those that holistically tackle physical, behavioral, and social needs, including support for housing, food, and transportation. Recognizing the integral roles caregivers and families play, VABs must also offer targeted resources to support a whole-family approach, such as employment support.

Additionally, it is essential to offer VABs for Members transitioning out of the benefit plan or child welfare system. By providing adequate support and resources, the SMCP can facilitate successful moves to independent living in the most integrated setting possible.

RECOMMENDATIONS

We recommend the following strategies to effectively integrate these benefits:

- A comprehensive benefit package, including timely transportation, to ensure care access
- Focusing on preventive services, in addition to treating acute and chronic conditions
- Developing interdisciplinary care teams that include primary care and behavioral health providers, pharmacists, school-based partners, specialists, and care management staff
- Employing a child- and family-centered approach, actively involving Members and their families or caregivers in care planning and decision-making processes
- Establishing feedback channels that allow families to provide input for continual improvement of service delivery

These strategies will ensure families are empowered to collaboratively design care plans that align with their needs and preferences and are culturally congruent.

4. Provider Network

4. PROVIDER NETWORK

Nevada currently faces an extreme deficiency in the mental health provider workforce across the state, complicated by low enrollment of providers participating in the Medicaid program. The creation of an SMCP for children with behavioral health needs would allow the SMCP to be intricately involved in the formation of a behavioral health system of care to better serve one of the Division's most vulnerable populations.

According to a 2023 Nevada Health Workforce study, 86.9% of Nevadans reside in a federally designated mental health professional shortage area (HPSA), with 100% of the rural population in an HPSA[1]. Nationally, Nevada ranks 51st for access to youth mental care services[2]. While there are many issues that contribute to this lack of appropriate access to providers and support, we recognize a key contributing factor to this gap is tied to mental health provider reimbursement rates.

REVIEW OF CURRENT FEE SCHEDULE REQUIREMENT

We agree with the Division's consideration to require the SMCP to pay, at a minimum, no lower than the Division's current Medicaid fee schedule to qualified providers to deliver behavioral health services to Members. By mandating this minimum payment level, and subsequent adjustment of certified actuarially sound capitation rates as allowed by CMS (42 CFR § 438.4(c)(2)(iii)(C)), the fee schedule would be incorporated into the capitated premium rate – ensuring increased payments are reflected in the compensation to providers.

According to the Nevada Psychiatric Association, low reimbursement rates have resulted in both Nevada-trained and out-of-state providers seeking employment elsewhere.[3] We believe a revised rate structure will encourage provider growth and retention across the state and increase the ability of the SMCP to partner with existing Medicaid providers to address youth mental health needs. This approach will expand and strengthen the workforce to address service gaps and the growing demand for youth behavioral health services in Nevada.

STRATEGIES FOR BUILDING AND MAINTAINING A BEHAVIORAL HEALTH WORKFORCE

We also recognize the importance of the SMCP in supporting providers transitioning into and participating in managed care. Our experience building and maintaining complex behavioral health networks, including those that serve foster care populations, has shown that most providers operate in small practices without the administrative infrastructure needed to quickly adapt to managed care. To minimize administrative burden and strengthen emerging networks, the SMCP must provide additional provider relations support that includes dedicated staffing, support resources, innovative claims processes, and utilization management training.

RECOMMENDATIONS FOR UTILIZATION MANAGEMENT AND QUALITY ASSURANCE

To effectively manage service utilization across the SMCP, additional strategies are recommended to build and maintain a high-quality network. This includes the SMCP establishing clear and evidence-based protocols, aligned with Early and Periodic Screening,

[1] Health Workforce in Nevada: A Chartbook – 2023 Edition
[2] https://mhanational.org/the-state-of-mental-health-in-america/data-rankings/youth-ranking/
[3] https://nevadamentalhealth.com/why-is-nevada-mental-health-ranking-low//

Diagnostic, and Treatment (EPSDT) service requirements. These protocols should include a system of care that will ensure efficient use of resources without compromising care quality, while easing the burden on providers for effective claims submission. The SMCP should also align with the Division's priority of reducing existing prior authorization requirements for high-impact care. For example, removing the need for prior authorization requirements for traditional, outpatient behavioral health services after a set number of sessions would reduce administrative burden on providers and benefit Members seeking care.

The SMCP should also embrace value-based payment models that incentivize quality care and positive outcomes. By designing and implementing value-based payment programs to address pediatric behavioral health needs through shared savings or bonus incentives, the SMCP can work alongside network providers to develop a high-quality, child- and family-centered system of care.

POLICY CONSIDERATIONS AND ADDITIONAL WORKFORCE DEVELOPMENT STRATEGIES

Additional measures to build and sustain a robust behavioral health workforce can be effectively supported through strategic public policy and workforce development strategies. These may include:

- State-supported loan forgiveness for behavioral health providers working at Certified Community Behavioral Health Clinics (CCBHCs), Regional Mental Health Clinics (RMHCs), or Federally Qualified Health Centers (FQHCs)
- Offering scholarships to students at public Nevada colleges and universities, contingent on a commitment to provide care within the state, to support the development of a larger behavioral health provider workforce
- The development and implementation of comprehensive, state-based trainings curricula focusing on addressing priority areas, such as trauma-informed care, culturally responsive care, and family engagement, particularly for intellectual and development disability (I/DD) and autism spectrum disorder populations; these training courses should include primary care providers (PCPs) to ensure a competent and knowledgeable workforce to support the integrated approach to addressing Member's whole-health needs

Our primary recommendations focus on building a robust provider network and fostering ongoing dialogue to ensure the success of a SMCP in Nevada. By doing so, the Division can facilitate greater provider involvement to address the behavioral health needs of the Medicaid-eligible children across Nevada.

5. Collaboration with Child Welfare, Courts, Counties, Schools, and Other Child-Serving Entities

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5. COLLABORATION WITH CHILD WELFARE, COURTS, COUNTIES, SCHOOLS, AND OTHER CHILD-SERVING ENTITIES

Children involved in multiple systems have complex needs that require a unified, collaborative approach to care. Anthem recommends embedding formal collaboration requirements into SMCP operations to ensure seamless coordination with child welfare agencies, courts, schools, juvenile justice systems, and behavioral health providers. This approach will address the needs of this vulnerable population by partnering with local agencies using a child- and family-driven system of care approach.

Care begins at enrollment with a health needs assessment and continues with ongoing engagement from care management teams. Key support partners for Members include the Division of Child & Family Services (DCFS), the Department of Juvenile Justice (DJJ), placement providers, and other formal agencies that understand the Member's history, conduct needed assessments, and recognize both immediate and long-term needs. Cross-sector collaboration is vital for achieving improved outcomes for children in foster care and those with behavioral health needs.

BEST PRACTICES FOR CROSS-SECTOR COLLABORATION

Shared systems and technologies can enhance communication. We recommend the Division consider requiring the integration of data systems to empower real-time collaboration amongst key stakeholders. This may include:

- Adopting **shared care planning tools** and participating in cross-agency case conferencing
- Implementing the use of secure, interoperable, **HIPAA-compliant data systems** to ensure real-time communication and information sharing
- Standardizing **service referral and transition protocols** across child-serving systems to reduce fragmentation and streamline access to care
- Collaborating through **community health care rounding** to facilitate interdisciplinary communication to address all aspects of complex Member needs and improve individualized care management
- Introducing a **standardized transition model** to provide consistency and continuity of care for youth moving between educational, health care, and residential settings to enhance their overall development and stability
- Engaging in **strong collaboration with school-based health care programs** to ensure school-age Members have easy access to essential health services, healthier learning environments, and improved educational outcomes

ENSURING TRANSPARENCY AND ACCOUNTABILITY

To promote transparency and accountability within the SMCP, it is important to set clear expectations for support and collaboration with child-serving partners and have strong systems for reporting and addressing any issues. This may be achieved through the following:

- Establishment of provider oversight on day one, with reporting mechanisms to ensure overall quality measures, including HEDIS-compliance from child-serving entities

- Regular engagement with child-serving partner entities to provide updates on SMCP activities, achievements, and challenges
- Surveys, focus groups, and workshops to solicit feedback from providers, caregivers, and families on their experiences collaborating with the SMCP
- Planning sessions to discuss upcoming initiatives, review progress, and make collaborative recommendations
- A structured resolution process that includes timelines and steps for investigating and addressing non-performance issues

ESTABLISHMENT OF SMCP COORDINATING COMMITTEE

A coordinating committee with regional and family representatives would support ongoing engagement, feedback, and cross-sector collaboration. Therefore, we support the establishment of a SMCP Coordinating Committee comprised of regional system partners, caregivers, and family advocates. This committee would serve as an advisory body, promote transparency, monitor performance, and facilitate problem-solving.

STRENGTHENING PARTNERSHIPS FOR ENHANCED SUPPORT AND ACCOUNTABILITY

To effectively address the diverse needs of Members, the SMCP should adopt strategies that promote strong partnerships and continuous improvement. We recommend the following collaborative strategies for the SMCP to enhance support and accountability:

- Dedicated liaisons to engage with county, child welfare, education, and court systems
- Partnerships with community crisis providers and facilities to ensure timely collaboration to address immediate needs, while planning for long-term support and wellness
- Innovate solutions, including personalized care plans that involve input from the Member and their support network, tailored to meet the unique needs of the child and their family
- Transparency through the establishment of shared goals and consistent communication, facilitated by an easily accessible and centralized communication platform
- Quarterly reporting on engagement metrics with partner entities
- Joint quality improvement efforts focused on discharge planning, placement stability, and school reintegration

Cross-system collaboration is essential in supporting children to achieve long-term stability in the least restrictive setting, while ensuring continuity across care transitions. We believe these recommendations would strengthen and enhance the effectiveness of ongoing cooperative efforts.

6. Solutions to Managed Care Pitfalls

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6. SOLUTIONS TO MANAGED CARE PITFALLS

Anthem advocates for a managed care model that is transparent, accountable, and community-focused. Below, we detail considerations and recommendations to address known challenges to managed care.

6.A. PERFORMANCE AND PUBLIC DASHBOARD

We support the creation of a public dashboard to ensure accountability, transparency, and quality of health care services provided through the SMCP. A sophisticated IT and data infrastructure dashboard drives consistent evidence-based decision-making to achieve high-quality Member outcomes.

To align with NCQA and HEDIS measures, we propose integrating key metrics related to EPSDT services, such as well-child visits, developmental screenings, immunizations, and behavioral health treatment adherence. These metrics are vital for ensuring thorough pediatric care and early intervention to ensure comprehensive care for children with behavioral health needs.

Additionally, incorporating Consumer Assessment of Health Care Providers and Systems (CAHPS) measures will capture Member satisfaction and experience feedback. Member experience metrics can provide insight into satisfaction and accessibility. By focusing on these evidence-based indicators, the dashboard can accurately reflect program quality aligned with the Division's Quality Strategy goals to improve health outcomes.

6.B. PROFIT V. NON-PROFIT ENTITY CONSIDERATION

The most important factor in Member care is partnering with organizations that can deliver high-quality, sustainable services, regardless of their operational structure. We recommend the Division establish robust evaluation criteria to ensure any entity, whether for-profit or non-profit, meets specific and consistent standards for service quality, community engagement, and risk management that reflect the needs of the population.

Although both for- and non-profit entities offer pros and cons, for-profit entities provide several advantages. These benefits include operational efficiency, enhanced provider access, capital access and flexibility, scalable infrastructure, innovative solutions, resource availability, and effective cost management. Their focus on performance outcomes ensures a commitment to and accountability for the well-being of vulnerable populations. Choosing partners with a strong capacity to meet care objectives will achieve the best results for this program.

6.C. VENDOR PAYMENT AND MEDICAL LOSS RATIO

We recommend a minimum Medical Loss Ratio (MLR) with a remittance to ensure the majority of program funds are spent on health care costs and improving health care quality rather than profit and administrative costs. Under 42 CFR § 438.8(j), the Division may choose to impose remittance provisions related to this MLR.

The current Medicaid Managed Care (MMC) and Nevada Check Up (NCU) contract contains a requirement for a managed care organization to pay a remittance to the Division if their reported MLR in a 12-month rating contract year is less than the contractual minimum MLR. We recommend the inclusion of similar language in the SMCP contract to help alleviate concerns by stakeholders about how state funds are utilized, Members are served, and providers are paid.

To reduce uncertainty in the development of the premium rates for the initial contract year, we recommend monitoring the emerging data and considering a mid-year premium rate adjustment if there are material differences identified in the initial assumptions.

6.D. COMMUNITY REINVESTMENT

Through our deep integration into communities across Nevada, we understand the importance of leveraging relationships with local community-based organizations to help close the gaps Members face in addressing their overall health. We recommend the SMCP be required to reinvest at least 3% of annual profits back into the community. We further recommend funds be allocated in tiered subgroups that align with the Division's priorities. Examples of these subgroups could include family support services, school-based mental health services, and health-related social needs (HRSN) initiatives.

We also recommend that the SMCP adopt a data-driven strategy to pinpoint and address Members' most common HRSN. This will help direct their reinvestment efforts effectively. Additionally, yearly reporting of these reinvestment activities to the Division would demonstrate progress and provide valuable insights for future strategy adjustments.

6.E. QUALITY WITHHOLD PAYMENTS

We fully support the Division's consideration of a withhold arrangement. This approach will drive meaningful improvements in service delivery and outcomes for children with behavioral health needs. It is critical that each performance measure used in this arrangement is assessed independently to accurately reward quality improvements. Independent assessment ensures progress in each specific area is recognized and incentivized, promoting a more focused enhancement in care quality. When selecting performance and quality metrics, alignment with the Division's existing Quality Strategy goals is essential. These metrics should be thoughtfully chosen to address the unique needs of the children served, ensuring they target the most impactful areas for improvement.

We propose a quality withhold in the first year of the contract, with premium earn-back based on reporting or operational measures, such as timeliness of data submissions and data accuracy. This would provide valuable insight into achievable quality targets. For the remainder of the contract term, we have found implementing a tiered improvement methodology is highly effective. Starting with higher targets for lower performing metrics and gradually setting smaller targets as metrics improve can help sustain motivation and focus across all areas of care.

If immunization measures are included in the withhold, it is important to address any prior Member matching issues within the registry to ensure that assessments and subsequent incentives are based on accurate and reliable data.

The mechanisms outlined above will help hold the SMCP responsible and improve care by aligning financial incentives with health care goals. Collaboration among providers, community groups, and managed care entities will enhance service quality and access for underserved children and families.

CareSource

TARGETED CASE MANAGEMENT

Strengthen and Streamline Targeted Case Management in the Foster Care System

CareSource supports the development of a specialty managed care system that not only ensures the stability of the current case management structure in Nevada but continuously strengthens, expands, and streamlines the local administration of these services for children and youth with behavioral health (BH) needs. Specific to child welfare (and the high proportion of foster care children with BH disabilities in the Silver State), the integration of a managed care model to serve this vulnerable population offers significant benefits such as expanded access to critical home and community-based services statewide, as well as the opportunity to address prevention and early intervention. In our experience, key outcomes include a reduction in the reliance on institutional and congregate care settings and a decrease in hospitalizations and lengthy residential admissions, to name a few. A holistic and family-centered model that emphasizes equity, accountability, and transparency—and seeks to bridge the gap between State and Specialized Managed Care Programs (SMCP) oversight and community-based expertise—is strongly recommended. Additionally, a commitment to a community-based approach also promotes workforce stability, positioning the SMCP as a vital entity to address workforce development barriers through a collaborative targeted case management framework that preserves local expertise.

Feedback on the Implementation of a Hybrid Case Management Model

Based on our assessment of the Washington State hybrid case management model, our recommendation is for the SMCP to:

1. Secure contracts with regional organizations to deliver county-led targeted case management services; consider holding these partners accountable with the introduction of quality drivers to systemically improve outcomes and promote high value care
2. Focus on case management oversight, standardization, and innovative solutions that address access to care issues; consider additional SMCP-owned responsibilities like data collection, utilization review, and the implementation of quality improvement programs.

From our experience, standardization is key for smooth and efficient operations and a SMCP oversight model allows for greater, more effective management. A county-led model also considers cultural preferences and community knowledge, which promotes member choice and continuity of care that is critical to success but even more so, for Nevada's foster population.

Best Practices and Recommendations

CareSource is invested in Nevadans and their health and wellbeing, especially children with specialty BH needs and those in foster care. We understand the transient nature of this population and the layer of complexity this adds to county-led management and SMCP oversight. Carefully considering this and the State's future integration of a SMCP, we put forth the following best practices and recommendations:

- **Child Welfare Statewide Advisory Group:** In partnership with the SMCP, provide funding and technical assistance to build capacity in rural and frontier counties, based on recommendations from this Advisory Group.
- **Transition Age Youth community program referral:** Require referrals to the Nevada Independent Living Program, Aged-Out Medicaid, which provides aids (i.e., life skills training) to foster and former foster youth for a successful transition from foster care to adulthood.
- **Evidence-based models and program offerings:**
  - Incorporate models and programs similar to those in Washington State like the Family Practice Model (FPM), Kinship Navigator Program, Mockingbird Family Model, Foster Care Assessment Program (FCAP), and Caregiver Support Projects.
  - Explore North Carolina's robust offerings for additional insights such as their expansion of home-based and intensive in-home family therapy models. Increased access to family-centered treatment has proven to reduce the need for foster care placement, divert from the emergency department, and decrease psychiatric residential treatment facility utilization.
- **Integrated Treatment Model (ITM) workgroup:** Develop a research-based treatment model that utilizes cognitive-behavioral principles and specifies appropriate interventions for individual youth in residential care and individuals and families upon return to home communities. We also suggest the

inclusion of a clinical consultation system accessible to all providers to ensure continuity of interventions and evidence-based practices.

Lessons Learned

We offer the following lessons learned to the Division for model enhancement considerations:

- **Stakeholder engagement:** The importance of stakeholder engagement cannot be overstated; conducting listening tours with child welfare entities, service providers, caregivers, and other key stakeholders during the planning process is crucial. Such engagement influences the upcoming procurement and Statement of Work, fostering a collaborative atmosphere where diverse perspectives can be shared. This ensures that the needs and concerns of all parties are addressed effectively.
- **Metrics that reflect whole-person outcomes:** It is essential to develop baseline and post-integration outcome metrics that facilitate real-time learning and adaptive problem-solving. By creating foster care-specific quality metrics that the State's Multi-Agency Collaborative Partnership can track longitudinally across systems, we enhance accountability. This approach builds stakeholder buy-in prior to statewide implementation and contributes to smarter resource allocation as well as more relevant reporting to the State.
- **Clinical assessment tool**: The selection of a clinical assessment tool is vital for informed decision making and service planning. This choice should align with the requirements outlined in the Settlement Agreement concerning input on an assessment tool. Based on our experience and expertise, we recommend the Child and Adolescent Needs and Strengths (CANS) tool. This tool is preferred because it can be administered in community settings and provides a comprehensive framework for evaluating the needs and strengths of children and families. Utilizing this assessment will not only guide service planning but also enhance the overall effectiveness of interventions, as they will be tailored to the unique needs of the individual and their support system.

Next Steps

CareSource recommends the Division respectfully consider the following next steps prior to SMCP integration for a more successful transition:

- Conduct **gap assessments** of local service providers to identify, better understand, and address inappropriate hospitalizations and extended lengths of stay.
- Host **Town Halls**—both in-person and virtual—that serve as informational hubs for future members, families, providers, and other key stakeholders in the foster care system.
- Issue a **phased rollout approach** to facilitate care integration across the state, allowing stakeholders the necessary time to adjust to the changes.
- Establish an ongoing **evaluation framework** to gather continuous feedback from all stakeholders. Utilize this feedback to drive strategic program and process improvement plans, ensuring the system remains responsive and effective to meet the needs of children and families.

In closing, we encourage ongoing collaboration and communication between the State, SMCP, and local experts and support local administration of targeted case management services to reach the Division's goal of not supplanting but bolstering Nevada's current foster care system.

CARE MANAGEMENT APPOACH

Best Practices for Care Management with the New SMCP Implementation

We appreciate the opportunity to provide the Division with input on care management best practices and our preferred approach. CareSource recommends the following best practices to deliver high-quality and intense care coordination services to children and youth with complex BH challenges, including those involved in multiple systems:

- **High-fidelity wraparound process:** Utilize a wraparound model with tailored services that are child- and family-centered. For tools and trainings on implementing this process, we suggest the Division

consult with experts from, for example, an academic institution such as Portland State University's School of Social Work where they launched the *National Wraparound Implementation Center*.[1]

- **Evidence-based programs:** Explore the Florida Statewide Medicaid Managed Care (SMMC) model and the offering of evidence-based programs to children exhibiting intense behaviors. Programs such as multisystemic therapy, parent-child interaction therapy, functional family therapy, Parents as Teachers, brief strategic family therapy, Healthy Families, and Nurse Family Partnership should be considered to provide comprehensive support and intervention strategies.
- **Family engagement:** Empower families to be partners in decision-making and offer a pathway to become a family or youth peer support specialist. An organization like the *Family-Run Executive Director Leadership Association (FREDLA)*[2] can provide further information and consultation.
- **Trauma-informed care:** This population, especially foster youth, often has a history of trauma, disrupted relationships, and systemic mistrust. Invest in and provide trauma-informed training for the SMCP, Care Managers, and provider partners.
- **Health information and data integration:** Implement data-sharing protocols for real-time member information to improve care management practices and prevent crises and duplicative services. Data sharing also reduces assessment fatigue for children and families and lessens the likelihood of re-traumatization, as the retelling of events can exacerbate symptoms of trauma.
- **Additional resources:** Discover more from experts like *Georgetown University Center for Child and Human Development (GUCCHD)* who offer policy guidance and implementation strategies for systems serving children with serious emotional disturbances (SED) or consult with the *Center for Health Care Strategies* for intel on their "Child & Family Health" focus area.

Best Approach to Ensure Statewide Availability of Quality Care Management Services

CareSource supports a Care Management Entity (CME) model, either contracted by the SCMP or separately procured by the State, with a limited number of highly qualified, regionally distributed CMEs. This model ensures statewide coverage while maintaining the flexibility to match local needs and provider capabilities. CMEs should operate as centralized specialty hubs for intense care coordination and commit to multi-system service integration that is focused on children with, or at risk of, significant BH needs.

Similar approaches have been implemented in other states (e.g., Maryland, New Jersey, Kentucky), supported by System of Care principles and wraparound models, both of which emphasize child- and family-centered, culturally competent, and community-based services. The SMCP provides oversight and standardization—in alignment with our recommendation for Question 1. Targeted Case Management. To support this partnership, the State should establish a clear definition of a CME and specify the qualifications required for designation. This clarity will enable the MCO to effectively utilize local expertise while ensuring accountability and consistent, high-quality care management.

The Division can also leverage expertise from the Intellectual and Developmental Disabilities (I/DD) care system in Texas, specifically the Local I/DD Authorities, to improve access to specialized care. Nevada would need to identify I/DD expert agencies throughout the State that are willing to become a preferred partner to serve as a CME and provide care management services for children and youth with both I/DD and SED or serious mental illness (SMI) diagnoses. We suggest incentivizing these providers to expand their scope of services and further drive home and community-based care.

BENEFIT SET

Feedback on Implementing an Integrated Benefit Set for Children

CareSource supports the Division's goal to achieve a "whole-child" approach to care and its efforts to seek feedback on the implementation of an integrated benefit set for children with complex BH challenges. Children, their families, and caregivers deserve care and services that are easy to understand, access, and use. Integrating medical care—including basic services, hospital services,

[1] National Wraparound Initiative. Regional Research Institute, School of Social Work, Portland State University. <National Wraparound Initiative (NWI)>
[2] Family-Run Executive Director Leadership Association (FREDLA). < Home | FREDLA>

pharmacy, and transportation—with BH services into a single coverage product will streamline the member experience while eliminating silos between home and community-based services and Medicaid medical benefits.

Best Practices and Recommendations

To effectively implement this integrated benefit set, we recommend the State:

- **Engage stakeholders.** Collecting input from children and youth, including families, caregivers, and service providers, is crucial to develop a system meeting the specific needs of this population. As detailed in our response to Question 1, we recommend establishing a Children's Advisory Group and conducting listening sessions across the state to survey youth and understand their viewpoint on care.
- **Provide meaningful digital tools and solutions.** Understand Nevada youth preferences and offer these digital tools to meet members where they are. We suggest the State and SMCP explore interactive apps for youth, digital supports for caregivers, and smart phone, tablet, and hotspot access for all to encourage social connections, telehealth visits, and care plan adherence.
- **Provide BH models or programs that integrate both in person and telehealth options.** Provide in person and on demand supports for greater access to expanded benefits.
- **Implement a Family-Centered benefit set.** This approach would aim to strengthen and preserve families, prevent entry and reentry into foster care, and support reunification and adoption.
- **Offer comprehensive provider communications.** Ensure providers understand how to navigate the integrated benefit set and implement the "whole child" approach effectively through communications. Examples include provider orientations, newsletters, advisory committees and SMCP.
- **Promote data sharing and collaboration among service providers.** Ensure providers are equipped with benefit set information to share with children and families for greater awareness and utilization.
- **Conduct continuous monitoring and evaluation.** Assess the effectiveness of integrated benefit offerings and gather insights for ongoing improvements.

Value-Added Benefits

In addition to Medicaid-covered benefits, we also support the Division's efforts to seek input on value-added and "in-lieu of" benefits that would support children and families. Recommendations include increased **peer support services** reimbursement to maximize community, family-centered care coordination to assist families in navigating the healthcare system. We suggest establishing a Member Assistance Fund to cover respite services, childcare, caregiver supports, tablets for telehealth, utility assistance, and a peer support training fund to improve access to Medicaid-covered peer support benefits. Focusing on transition-aged youth, the State should offer value-added benefits that exceed funds available through Independent Living offerings. **Expanding transportation assistance** beyond Medicaid benefits will ensure access to necessary appointments, while educational support services (such as Life Coaches or assistance in obtaining a GED) can address the educational needs of children with BH challenges. Furthermore, **wellness and preventive services**, such as nutrition programs and mental health awareness campaigns, can enhance overall well-being. Suggestions include memberships to organizations like the YMCA or Boys and Girls Club and providing digital resources for fitness and connectivity, particularly for those in rural areas (e.g., devices for internet access and sensory/safety kits).

Lessons Learned

CareSource recommends the State evaluate programmatic requirements and offerings with a rural and frontier community mindset first, ensuring access for those most vulnerable. Lessons learned from similar implementations highlight the importance of **flexibility in service delivery** to accommodate diverse family needs, building trust through consistent communication and responsiveness, and **addressing barriers to access** that families may encounter. We also suggest utilization data collection and monitoring to help identify what is working and what can be expanded on.

PROVIDER NETWORK

Strengthening the BH Care Continuum and the SMCP

CareSource strongly supports Nevada's future investments in behavioral health and encourages the State to prioritize building critical infrastructure as a first step—such as offering grants to help providers establish and staff new levels of care—followed by targeted enhancements to behavioral health

reimbursement rates to ensure long-term sustainability. CareSource understands that Nevada's behavioral health system, especially for children and youth, faces critical challenges related to access, provider participation, and service availability. Many behavioral health providers opt out of Medicaid due to administrative burden and low reimbursement rates, contributing to significant service gaps across the continuum. This includes limited availability of in-home services, inpatient mental health care, peer support, treatment for youth with I/DD and co-occurring behavioral health needs, and respite care.

Additionally, Nevada has experienced an increase in out-of-state placements due to the lack of in-state residential treatment options, and these systemic issues are further exacerbated by national crises in youth mental health and severe shortages across the behavioral health workforce. To support the development of a new SMCP network, we believe Nevada should implement a comprehensive strategy that addresses both immediate service gaps and long-term system sustainability. A central focus must be placed on expanding and strengthening the behavioral health workforce.

Recognizing similar challenges, Nevada hospitals worked collaboratively with state leaders to adopt an expanded provider tax, using a portion of the additional revenue to strengthen funding for BH services. We support using this innovative funding to increase service availability and improve access through initiatives such as:

- Expanding loan repayment and tuition assistance programs for behavioral health professionals who serve Medicaid populations in underserved regions.
- Advocating for additional funding and expansion of GME loan pool to include mid-level physicians.
- Incentivizing partnerships with academic institutions to create training pipelines, including internships, clinical residencies, and supervision opportunities for provisionally licensed clinicians.
- Inclusion of community health workers and peer support specialists by funding training and certification, and ensuring these services are billable at a viable rate under Medicaid. The current under-reimbursement of peer support services hinders recruitment and the availability of services.

In terms of service delivery infrastructure, Nevada should prioritize expanding in-state capacity for residential treatment and intensive in-home services through capacity building and infrastructure grants. Investment in the Crisis Now model for statewide mobile crisis response teams, wraparound services, and telehealth platforms will further help mitigate gaps in care, especially for youth in rural areas. Regional centers of excellence should be developed for youth with I/DD/autism and behavioral health needs, providing comprehensive, multidisciplinary services close to home. The SMCP should be required to demonstrate network adequacy for these priority services and provide recruitment and capacity-building plans to address provider shortages.

Other strategies to expand care in Nevada include introducing Community Health Workers (CHWs) to provide preventive services covered by Medicaid, based on recommendations from licensed Medicaid-enrolled providers. Many states have successfully incorporated CHWs into their systems through state plan amendments or Section 1115 waivers. Managed Care Plans (MCPs) can hire and train CHWs and collaborate with trusted community health organizations to ensure a strong community focus. Additionally, expanding the scope of existing providers to integrate oral health into children's primary care—such as the application of fluoride varnish—supports alignment with Child Core Set health care quality measures. To increase the number of providers allowed to practice within the state or through providing telehealth services, we recommend increasing participation in Interstate Licensing Compacts.

To enhance services and increase capacity, we recommend supporting flexible payment policies that attract providers and increase services. For example, reimbursing evidence-based practice models that can be delivered by bachelor's level clinicians. This approach is advantageous because bachelor's level clinicians are more readily available and utilizing them would help preserve the limited supply of clinically licensed staff. One highly effective model is Family-Centered Treatment, which has demonstrated significant success in addressing the needs of families and youth in behavioral health care by reducing length of stay in psychiatric residential treatment facility and shows significant improvement of safety measures when children return home. Policies could offer enhanced payments or financial incentives for delivering child- and family-centered care, particularly in support of state child health priorities such as better integration of physical and behavioral health services. These incentives, provided to participating

primary care clinics, can strengthen provider relationships, boost satisfaction, and ultimately improve health outcomes for children and their families.

Provider reimbursement strategies must be reformed to enhance sustainability and incentivize quality outcomes, as traditional fee-for-service models fail to attract and retain providers, particularly for high-intensity or community-based services. Nevada should implement value-based payment (VBP) models that reward meaningful outcomes, such as reduced hospitalizations and improved family stability, while offering enhanced rates and start-up grants to support critical services like respite care and peer support. Additionally, the SMCP should adopt a phased VBP implementation plan with provider input and reinvest shared savings into network development. As Nevada considers whether to require reimbursement rates no lower than the current Medicaid fee schedule, establishing a minimum reimbursement floor tied to this schedule would ensure providers are not financially disadvantaged. While maintaining this floor, Nevada should also allow for higher payments based on provider performance and access to high-need services, fostering investment in children's services while encouraging ongoing improvement and innovation.

The state should prioritize investing in children's services by enhancing and increasing rates for programs that support child health and development. Early, robust investment in children yields significant long-term returns — both in individual health outcomes and in broader system savings. Research consistently shows that addressing physical, behavioral, and social health needs early in life leads to healthier adults, reducing the demand for costly interventions later. By strengthening services for children now, the state can improve the immediate well-being of its youngest residents and build a healthier, more resilient population for the future. Investing at the child level is the most effective and fiscally responsible strategy to promote long-term public health and control future healthcare costs.

Administrative burden remains a significant deterrent to provider participation in Medicaid. Utilization management processes must be streamlined and standardized to reduce delays in care and provider frustration. Prior authorization should be waived or expedited for evidence-based and crisis-related services. Currently a best practice in many markets, Nevada should consider establishing a centralized technical assistance hub to support providers with billing, documentation, and compliance under the SMCP. The SMCP should also be required to maintain provider liaisons and billing specialists to support new and smaller providers navigating Medicaid systems.

In conclusion, the development of a new SMCP presents a strategic opportunity to address long-standing behavioral health challenges in Nevada. A comprehensive approach that prioritizes workforce development, service expansion, provider sustainability, and administrative simplification will be essential for improving outcomes for children and youth. These recommendations offer a roadmap for ensuring that the new SMCP can support a high-functioning, responsive, and equitable behavioral health system.

COLLABORATION WITH CHILD WELFARE, COURTS, COUNTIES, SCHOOLS, AND OTHER CHILD SERVING ENTITIES

Nevada Medicaid seeks to align efforts across multiple state and local agencies responsible for children with BH needs, particularly those in foster care or other intersecting systems. To ensure effective service delivery and care coordination, CareSource agrees that a SMCP should foster cross-sector collaboration, including with child welfare, courts, schools, and juvenile justice. This collaboration will require shared outcomes and performance goals, systems, technologies, and processes for children served by multiple entities. CareSource believes Nevada should develop formal Memoranda of Understanding (MOUs) or Agreements (MOAs) between the SMCP and key child-serving agencies. These agreements should clearly define roles and responsibilities to include shared performance metrics, streamline referral processes, establish data-sharing protocols, and outline escalation and dispute resolution procedures. To be effective, this type of collaborative should also include cross-sector training for collaborative members in the evidence-based practices in use for each sector and how those evidence-based practices contribute to shared system outcomes. Nevada Medicaid should also leverage existing technical

assistance related to implementing cross-sector collaborations to assist key stakeholders in the design and execution of this initiative.[3]

To enhance communication and coordination, Nevada should invest in interoperable digital platforms that allow real-time updates, facilitate cross-agency communication, and integrate case management tools. This shared platform must also accommodate consent management for minors and ensure compliance with confidentiality regulations. Such systems will advance data utilization to drive informed decision making as well as enable more efficient, transparent service delivery for children across the state's diverse systems.

CareSource believes that it is critical for the SMCP vendor to have dedicated interagency liaisons employed to oversee coordination between child welfare, juvenile justice, schools, and other systems. These liaisons should have expertise in trauma-informed care, educational systems, evidence-based practices for delinquency prevention and recidivism reduction, and mental health services, ensuring that each child's needs are addressed across systems. In addition, the SMCP must participate in cross-training programs with these partner agencies. These trainings should focus on trauma-informed care, wraparound service delivery, legal confidentiality considerations, and cultural competency to improve outcomes for children and families.

Transparency and accountability are essential to ensuring the SMCP is meeting the needs of children and their families. Nevada should develop public-facing performance dashboards that can help track health disparities and include key metrics—such as the timeliness of service delivery, service coordination across systems, family, and youth satisfaction scores, data on grievances and resolutions, and important systems outcomes. As part of this effort, Nevada should create a comprehensive Child Health and Outcomes Dashboard that publicly displays performance data, including:

- Demographics, prevalence of conditions, and health data of covered children.
- Quality Measures (including HEDIS, Child core set, Behavioral Health Core Set, and member satisfaction).
- Screening and Assessment data (vision, hearing, dental, lead, etc.)
- Access to Care (waitlists, bed availability, etc.)
- Referral, Treatment, and Service utilization (time between screening and follow up treatment, use of community-based services, referral completion to specialists, etc.)
- EPSDT (authorization patterns, denial rates, geographic access to providers, grievance and appeals related to EPSDT services)
- Psychotropic medication monitoring (prescribing trends, first-line psychosocial care, etc.)

Relevant cross-sector outcomes (e.g., out of home placements for child welfare, recidivism, or penetration into institutions for juvenile justice, school retention and success measures, etc.) Furthermore, Nevada should publish a "menu of services and supports" to ensure that all child-serving agencies understand the levels of service they can expect from the SMCP. Regular briefings with partner entities should also be hosted to promote alignment and identify gaps in service.

To hold the SMCP accountable, Nevada should implement a non-performance reporting mechanism that allows child-serving partners, such as judges, caseworkers, and school administrators, to submit concerns about the SMCP's responsiveness or service delivery. This system would allow for tracking issues, escalating concerns, and publicly reporting non-performance trends in a de-identified manner.

Nevada Medicaid should also consider establishing a Youth and Family Advocacy Council comprised of individuals with lived experience. The Youth and Family Advisory Council will consolidate feedback, barriers, and solutions to inform a separate Coordinating Committee for the SMCP, additionally composed of regional representatives from child welfare, juvenile justice, education, and behavioral health. This committee would serve as an advisory body, reviewing SMCP performance, providing input on proposed innovations, and identifying areas for corrective action. It should meet regularly and ensure ongoing,

[3] RFK National Resource Center for Juvenile Justice for sample technical assistance tools (https://rfknrcjj.org/resources/dual-status-youth/)

actionable feedback from all relevant stakeholders. Finally, CareSource believes the SMCP should adopt best practices, including the implementation of wraparound care coordination, where each child is assigned a dedicated care coordinator. This will help ensure that children receive comprehensive services across systems. The program should also include peer support roles for both families and youth to foster empowerment and engagement. Care transition protocols should be standardized for children when they experience school changes, placement changes, or reentry into the system. Early identification through behavioral health screenings in schools and juvenile justice settings should be prioritized to address issues proactively.

These recommendations aim to ensure that Nevada Medicaid's SMCP fosters a well-coordinated, transparent, and accountable system that meets the needs of children with behavioral health concerns, particularly those navigating multiple systems. By establishing strong partnerships, clear communication, and data-driven oversight, Nevada can improve outcomes for vulnerable children and their families.

SOLUTIONS FOR MANAGED CARE PITFALLS

Nevada's SMCP presents a critical opportunity to build a responsive, transparent, and accountable system of care for Medicaid-eligible children and youth with behavioral health needs. Across the country, specialty managed care programs serving high-risk, high-need youth have shown the greatest success when built on foundations of performance transparency, community reinvestment, and strong outcome-based incentives. CareSource believes the following recommendations reflect national best practices and are tailored to the priorities outlined in Nevada's Settlement Agreement and its broader efforts to transform children's behavioral health.

A. Performance: Transparency and Public Accountability

CareSource strongly supports the Division's consideration of a public dashboard as a mechanism to enhance transparency, build trust, and engage families and stakeholders. States like New Jersey and Washington have demonstrated the value of publicly accessible dashboards in promoting accountability through real-time, understandable reporting of quality indicators.

For Nevada, the dashboard should highlight metrics specifically relevant to the unique needs of its target population and be aligned with the SAMHSA Children's National Outcome Measures already being collected. These may include timely access to care, the balance between community-based and institutional services, placement stability for children in foster care, chronic absenteeism, and youth-reported quality of life measures. Additional metrics—such as use of crisis services, diversion from higher levels of care, and follow-up rates after hospitalization—would further support Nevada's goals of strengthening care continuity and reducing system over-reliance on institutional placements.

B. Profit vs. Non-Profit: Prioritizing Mission-Driven Partnerships

We recommend that the procurement process place strong emphasis on vendors' demonstrated commitment to community reinvestment, collaborative partnerships, and outcome-driven performance. Non-profit entities are often inherently aligned with these values, offering a proven track record of service to vulnerable populations. By prioritizing organizations with a history of measurable impact and deep-rooted community engagement, Nevada can ensure that its SMCP partner is well-equipped to meet the complex needs of children and youth.

C. Vendor Payment: Financial Accountability and Quality Reinvestment

To ensure most of the funding directly supports care delivery, CareSource recommends establishing a minimum medical loss ratio (MLR) of 90% for the SMCP—consistent with national best practices for high-need populations. States such as New Mexico and Arizona have adopted this standard successfully, resulting in greater investment in direct services. We further propose that any remittances resulting from failure to meet this MLR be pooled into a state-directed quality improvement fund. This fund could be strategically reinvested in high-performing providers and in critical services such as crisis stabilization, respite care, and workforce development—particularly in Nevada's rural and frontier communities, where service access is most limited.

D. Community Reinvestment: Required Community Reinvestment

We endorse the Division's proposal to mandate community reinvestment from annual SMCP profits. States like Oregon and Massachusetts have implemented similar requirements with measurable benefits for vulnerable youth. Nevada should require that 3–5% of annual profits be reinvested in non-Medicaid reimbursable activities that address social determinants of health and fill service gaps. Potential uses include workforce development, peer and family support programs, community-based respite, health-related social needs, and targeted support for foster and kinship caregivers. These reinvestments would strengthen the local service network, reduce reliance on out-of-state placements, and enhance the continuum of wraparound support for children and families.

Nevada should establish a dedicated advisory committee specifically for the specialty Medicaid managed care plan. This committee would be responsible for defining community reinvestment requirements and parameters to address social drivers of health, fill service gaps, improve systems of care, and increase access to services. While Nevada has already established the Medicaid Reinvestment Advisory Committee, a focused committee for the specialty plan would ensure targeted oversight and strategy development aligned with the unique needs of the population served. Nebraska provides a model through its Excess Profit Fund, where excess managed care profits are treated as state funds and used for initiatives eligible for federal matching. These funds support programs such as evidence-based early intervention and nurse home visiting, which benefit from a $3 federal match for every $1 invested by the state.

E. Quality Withhold Payments: Performance-Based Incentives

We also support the implementation of a quality withhold arrangement, recommending that 3–5% of the monthly capitation payment be withheld and released only upon achievement of key performance benchmarks. Metrics should center on outcomes most meaningful for this population—such as successful transitions from residential to community-based settings, timely engagement in follow-up care (within 7 and 30 days of discharge), placement stability for children in foster care, reductions in out-of-state placements, family and youth satisfaction, and demonstrable improvements in behavioral health outcomes. Performance-based incentives such as these have been effective in driving continuous quality improvement in other states, and they offer a powerful lever for achieving better results for youth with complex needs.

In closing, Nevada has a unique opportunity to create a managed care program that not only improves access and outcomes for children and youth with behavioral health needs but also strengthens the broader system of care. By integrating transparent public reporting, meaningful community reinvestment, financial accountability, and outcome-driven incentives, the SMCP can serve as a model of innovation, equity, and effectiveness in children's behavioral health.

RFI Feedback from Potential Bidders – Specialty Managed Care Plan for Children

1. Care Management Structure

We recommend that Nevada adopt a **targeted case management (TCM) model** through a **sole-source contract** to ensure continuity of care and reduce risk for children with complex needs. Monthly collaborative meetings should be held between the contractor, the state, and other involved entities to streamline processes, track performance, and align care delivery.

Covered Diagnoses should include:

- Intellectual and developmental disabilities (IDD)
- Serious emotional disturbance (SED)
- Autism spectrum disorder
- Developmental delays
- Cerebral palsy
- Non-ambulatory conditions
- Any diagnosis requiring an Individualized Education Plan (IEP)

We also recommend implementing **caseload limits** and using a **high-fidelity wraparound approach**, similar to Washington State, to ensure quality care and member engagement during transitions or acute care events.

2. Care Management Entities (CMEs)

We support the formation of a **multidisciplinary team within DHHS** to oversee training, engagement, and communication with providers, stakeholders, and families. This team should host public workshops, solicit feedback, and ensure transparency in the development and implementation of home and community-based services.

Clear delineation of roles across entities providing TCM is essential. We recommend adopting best practices from the Washington plan to define responsibilities and ensure safety and permanent supports during transitions of care.

3. Integrated Benefit Design

The benefit set should reflect a **whole-child approach**, incorporating medical, behavioral, and social supports. We recommend including services for children with co-occurring conditions and those involved in child welfare or juvenile justice systems.

Connect Our Kids (501c3) is a national organization supporting foster youth and families. Their tools and services could enhance Nevada's SMCP by supporting emotional and mental well-being. More information is available at connectourkids.org.

4. Provider Network and Reimbursement

To strengthen the behavioral health workforce, we recommend:

- Aligning provider networks across products (e.g., auto opt-in for providers already contracted under the Battle Born Plan)
- Using the same **Fee-For-Service (FFS) base rate language** as the statewide Medicaid contract
- Funding "clarity meetings" to ensure proper allocation of payments from Title IV-E and McKinney-Vento sources

5. Cross-System Collaboration

We recommend the state collaborate with the SMCP to establish **data sharing standards** that:

- Reduce duplication in assessments
- Enable information exchange with schools, health plans, and child-serving agencies
- Include performance metrics and **monetary penalties** for failure to share required data

Routine touchpoints and shared data flows will improve care coordination and reduce inefficiencies.

6. Performance and Accountability

We support an **outcome-based care model** that holds providers accountable using quality metrics such as:

- Follow-up after hospitalization for mental illness
- Follow-up after emergency visits for mental illness or substance use
- ADHD medication management
- Metabolic monitoring for youth on antipsychotics

We recommend linking reimbursement to performance on these metrics to drive quality improvements.

Additional Notes

- Many sister agencies have expressed interest and requested clarification on implementation timelines and processes.
- There is a strong need for **ongoing communication and transparency** to ensure stakeholders understand their roles and expectations.

May 23, 2025

Solicitation of Public Input Regarding the Implementation of a New Specialty Managed Care Plan for Certain Children and Youth Populations

To whom it may concern,

I am the Director of Eagle Quest, Nevada's largest Specialized Foster Care (SFC) agency. I also represent the Family Focused Treatment Association (FFTA), which is a national organization that works to advance best practices and advocate for policies that support families in their care and treatment for children. The Nevada FFTA Chapter currently has approximately 600 therapeutic foster care beds statewide. Our FFTA member agencies deliver a wide range of Treatment Family Care services including, but not limited to: Family Preservation, Home Visitation, Foster Care, Adoption, Kinship Care, Older Youth Services, Parent/Family Support, Mental Health Services, etc.

I am writing the Nevada Division of Health Care Financing and Policy in effort to prevent unanticipated consequences to the vulnerable youth who reside in our state's foster care system, as we embark upon transition from Fee-For-Service coverage to a Specialty Managed Care Plan (SMCP). Historically, in our state we have operated in silos and not had open dialogue amongst partners and stakeholders. The Nevada FFTA chapter would like to formally express our interest is serving on any advisory committees created pertaining to the transition of a SMCP for foster children. Our advocacy group desires to ensure the best interest of foster youth is at the forefront. We also want to ensure a SMCP transition appropriately supports the select group of providers offering Specialized Foster Care services throughout our state. We have all heard of some of the potential pitfalls associated with managed care expansion and would like to mitigate those to the greatest extent possible.

I personally have been a foster parent for over 20 years in Clark County and believe my experience in navigating the system and advocating for foster children would prove to be highly beneficial in an advisory capacity, as we transition to a SMCP for our most vulnerable and at-risk children.

In regard to public input and comment pertaining to Care Management Approach (#2), FFTA membership would suggest consideration for established SFC agencies whom are nationally

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accredited to serve in the role as Care Management Entities (CME's) for Nevada's foster care population. We believe SFC agencies could serve as an effective centralized hub for care coordination. We feel as though SFC agencies are already doing a significant amount of the intensive care coordination for our most vulnerable youth and we would like to formalize the process, and would encourage DHCFP to consider us to serve in the role as CME's.

In regard to Benefit Set (#3), FFTA membership would appreciate being involved in the integrated benefit set discussion. Our membership would like to highlight the significant barrier that transportation poses for our foster youth; it continues to be a huge obstacle on multiple fronts for our most vulnerable children. We are in favor of removing unintended silos and hope that the provider agencies serving these at-risk youth can be compensated for all the services which they provide to include: transportation, case management, Child and Family Team (CFT) meeting facilitation etc.

In regard to Provider Network (#4), it is paramount that the Division requires the SMCP to honor and pay, at a minimum, no lower than the state's current Medicaid fee schedule to qualified providers for the delivery of behavioral health services to this child population. Nevada presently and historically has experienced a critical provider shortage of those willing to accept Medicaid and serve our most vulnerable youth. Lower rates than the current, antiquated rates would inevitably promote accessibility issues for our most disadvantaged youth; many of whom reside in the foster care system. It is critical that we take a step forward for our children and not a step backward; fair rates in a world with unprecedented inflation must be a priority. *(Therapy rates haven't been formally adjusted since 2013; this is perhaps the only field I know of, which hasn't received a rate increase in over a decade; no wonder we have service accessibility issues pertaining to key clinical services; our children are inevitably and adversely affected by this.)*

In regard to Collaboration with Child Welfare, Courts, Counties, Schools, and Other Child-Serving Entities (#5), FFTA membership cannot emphasize enough the importance of supporting and forming both coordinating and advisory committees for the SMCP. We believe the creation of the aforementioned committees it critical to informed decision-making, best practice and the reduction of unanticipated consequences for our most disadvantaged youth. FFTA membership would like to formally express our desire to participate on any coordinating, or advisory committees created.

In regard to Solutions to Managed Care Pitfalls (#6), FFTA membership is supportive of tracking performance of the new SMCP and its network providers; transparency and early identification of looming issues are critical. We also encourage the Division to require some level of community reinvestment for the SMCP with respect to profits earned via operating the managed care program. We believe there will be more support of the SMCP if they reinvest back into our local community with activities designed to support and benefit the targeted population. In regard to quality withhold payments, our membership would like to emphasize that if the Division chooses to withhold a portion of the vendors monthly capitation payment, that it doesn't

result in an adverse or lengthy delay in payment to network providers who perform well and serve the targeted population. Our membership has learned from provider agencies operating in other states that managed care organizations (MCO's) often have a significantly delayed/lengthy payment timeframe/structure to service providers, as compared to Fee-For-Service coverage plans.

In conclusion, FFTA membership appreciates the opportunity to express our opinions and suggestions. We applaud the Division for proactively reaching out to solicit input from our community and provider groups to ensure a smooth transition from Fee-For-Service to a SMCP. We believe the creation of advisory committees will reduce the potential risk for unanticipated consequences to the vulnerable population the SMCP is intended to serve. We look forward to ongoing discussion and active participation throughout the next year; our youth are without question deserving of a better and more comprehensive system to meet their unique needs.

Thank you for your time and consideration.

Intermountain Children's Health

New Specialty Managed Care Plan – Feedback

- Under eligibility be sure to define "the variety of factors"
- **Targeted Care Management**
  - Utah has several lessons learned for Targeted Case Management, including:
    - To be successful in this domain, being able to share records will be imperative
    - Ensuring there is an audit system to verify providers, and the Care Management teams are doing workflows and processes to fidelity will be beneficial
    - There will need to be a way to share resources and services across this team
    - We recommend you clearly define roles and responsibilities
    - We recommend you develop a similar language across the state. Utah had many names for the same job title and job descriptions, leading to confusion and duplicative work
- **Care Management Approach**
  - It would behoove the state of Nevada to have a shared database across the state for accepting mental health providers. This database should have any information that would help a care manager, including:
    - Availability of the provider
    - Ability to schedule appointments
    - Ages the provider treats
    - Ability to submit a referral
  - We recommend a MOU, contract, etc. with community providers that ensure quick access into some specific programs
- **Benefit Set**
  - A good example of this would be Huntsman Mental Health Institute (HMHI) Home Program
- **Provider Network**
  - Regarding increasing training and developing the workforce, we recommend a few things:
    - Look for opportunities for funded training placements
    - Funded site visits to ensure fidelity
    - Enhanced reimbursement for having a student/trainee
  - Additional ideas include:
    - High reimbursement for general practitioners
    - Value Based Care model
    - Outcome based payment/incentives
    - Incentives for participating in quality initiatives
    - Reimbursement only for evidenced based models
    - Pay more to providers who are willing to accept clients with higher acuity. A good example of this is Healthy Steps out of Washington DC.
      - Be sure to validate these providers can care for a higher acuity population
  - There are typically three reasons providers do not want to contract with Medicaid:
    - Clients are more complex
    - Less reimbursement

        - High administrative burden through excessive paperwork, rigid rules, and antiquated workflows. To increase the willingness to participate, consider changing one or more of these three items
- **Collaboration with Child Welfare, Courts, Counties, Schools, and other Child Serving Entities**
    - The biggest opportunity lies in easily sharing information. We strongly recommend using the same documentation system to increase the ease of sharing information
    - Other strategies might include having families carry a credit card/card where you can upload all your documents to that card and the client can transport the medical information with him/her/them.
- **Solutions to Managed Care Pitfalls**
    - Performance
        - Possible metrics include:
            - HEDIS Measures
                - ED Volumes
                - Recidivism rates
                - FUM/FUH Rates
                - Metabolic monitoring for antipsychotics
            - # of out of state placements
            - % of clients on multiple psychotropics
            - % of clients on antipsychotics
            - Baseline functioning metrics/quality of life metrics
                - Graduation rates
                - FMLA rates due to children and mental health needs
                - School attendance
    - We recommend a nonprofit entity, as this seems more aligned with high quality treatment, coupled with operational efficiency
    - Quality Withhold Payments
        - The state of Washington has had some success with this strategy

Intermountain Children's Health

NV BH response specific resources and references:

Research and Evidence-based practice
https://static1.squarespace.com/static/5935ee95893fc011586f1304/t/669935a4c5577a6233e5b01e/1721316775061/2024+Reporting+Guide+final_reduced+for+web.pdf
https://static1.squarespace.com/static/5935ee95893fc011586f1304/t/66fda4f92b9f6d09b751812f/1727898874161/RER+2024+EBP+Reporting+Guide_final.pdf
Value-based payment models for BH
https://static1.squarespace.com/static/5935ee95893fc011586f1304/t/635182355d81eb1bfeedc2b0/1666286136738/VBC+report_final+for+distribution.pdf
School-based approaches
https://smartcenter.uw.edu/
Training example
https://uwcolab.org/learning-health-system

Helpful resources:

University of Washington CoLab Community and Behavioral Health Policy
https://psychiatry.uw.edu/research/colab-for-community-behavioral-health-policy/
University of Washington Evidence Based Practice Institute
Evidence Based Practice Institute — CoLab for Community and Behavioral Health Policy
UW Alacrity Center
https://psychiatry.uw.edu/research/alacrity-center/

Intermountain Children's Health

6355 S Buffalo Dr. Las Vegas, NV 89113 | P 702.318.2400 |
intermountainhealthcare.org/childrens-health

Date Fri 5/16/2025 12:22 PM

To Children's Behavioral Health <ChildrensBH@nvha.nv.gov>

Dear State Development of a Managed Care Plan

I am writing to express the urgent need for increased support and resources for behavioral health services. Access to comprehensive and timely care is essential for individuals facing mental health challenges, ensuring their well-being, stability, and ability to thrive in their communities.

The need to access to professional care, community support programs, workplace and school resources, crisis prevention & intervention, and equity and accessibility.

Investing in behavioral health not only improves individual lives but strengthens families and communities. Expanded resources, equitable access, and improved policies can make a meaningful difference in ensuring effective and compassionate care.

I respectfully urge SMCP to prioritize behavioral health needs by increasing funding policy changes, community base initiatives, education and awareness, and equitable access and crisis intervention services. I appreciate your time and commitment to addressing this crucial issue, and I am hopeful that together, we can make a lasting impact.

Thank you for your consideration. Please feel free to contact me if you require any additional information.

Input Regarding the Implementation of a New Specialty Managed Care Plan for Certain Children and Youth Populations

Response to item # 4

To ensure the long-term sustainability of Nevada's behavioral health infrastructure and to effectively address persistent workforce shortages, service gaps, and low provider participation in Medicaid, we recommend the implementation of a **behavioral health capitation model**—particularly for levels of care 1 through 4.

The primary reason many behavioral health providers abstain from enrolling in Nevada Medicaid is due to **reimbursement rates that are insufficient to cover the administrative and clinical costs** associated with delivering care. Providers must meet extensive documentation, compliance, and prior authorization requirements that are labor-intensive and often unreimbursed. The administrative burden, when coupled with the low fee-for-service (FFS) rates, makes participation financially unfeasible—especially for small and mid-size practices, community nonprofits, and agencies serving high-need youth populations such as those with autism, intellectual/developmental disabilities (IDD), or co-occurring disorders.

A **capitated payment model**—where providers are paid a fixed per-member-per-month (PMPM) rate to deliver a defined set of services—offers several benefits over the current fee-for-service approach:

1. **Predictable Revenue Supports Sustainability**
   Providers gain **financial predictability and stability**, enabling them to hire and retain staff, build service capacity, and invest in training and infrastructure without relying on unpredictable billing cycles.
2. **Reduces Administrative Waste**
   Capitation minimizes **billing complexity, claim denials, and back-end audits**, freeing up provider resources for direct care rather than paperwork and compliance overhead.
3. **Encourages Holistic and Preventive Care**
   With an assigned panel of youth and families, providers are **incentivized to invest in early intervention, family support, and preventative services**—rather than waiting for crisis-level reimbursement triggers under FFS.
4. **Supports Integration and Continuity of Care**
   Capitation allows behavioral health organizations—both nonprofit and for-profit—to **strategically coordinate services across levels of care** , reducing fragmentation and unnecessary out-of-state placements.
5. **Builds a Resilient Provider Network**
   With guaranteed monthly payments and enrolled populations, provider organizations are better positioned to **scale operations, participate in training programs, and build the clinical workforce Nevada desperately needs.**
6. **Aligns with Value-Based Care**
   A capitated structure can be paired with **quality incentives or outcome-based bonuses** to reward high-performing providers and drive equity-focused, evidence-based care across the state.

To maximize continuity of care and resource accountability, we recommend that under the State Medicaid Capitated Program (SMCP), youth be **assigned to a primary behavioral health provider** based on geography, specialization (e.g., IDD, autism), and provider capacity. These providers would then be accountable for delivering or coordinating all services within levels of care, supported by PMPM capitation payments.
The current Medicaid fee-for-service model is neither equitable nor sustainable.
A **capitated behavioral health structure**—tailored to youth needs and implemented through both nonprofit and for-profit partners—would **strengthen Nevada's provider infrastructure**, improve health outcomes, and deliver long-term cost efficiency for the state.

Re: Solicitation for Public Input Regarding the Implementation of a New Specialty Managed Care Plan for Certain Children and Youth Populations

I am submitting this input on behalf of the Children's Attorneys Project at Legal Aid Center of Southern Nevada, where we provide a right to counsel for the thousands of children in the child welfare system in Clark County, Nevada.

In serving the foster youth population, we are in the trenches with our clients on their needs, whether it be a deaf child's inability to access hearing aids or a lack of space available for a child in an active mental health crisis.

We see the following as the main issues of concern going into this planning:

1. **Adequacy and expansion of provider networks for both medical and mental health needs to increase quality and access to care**

   Maintaining and supporting the extremely limited providers we have right now has been extremely difficult. We have many questions as to how these changes will impact the providers that we are overly reliant upon, particularly in the mental health space. There can be no disagreement that we have to expand our network, but "growing pains" to reach that goal could be life threatening and cause crisis to our youth currently receiving services. In practice, it can feel like these children are competing for most urgent and dire case deserving of a last available spot, while the others are relegated to a waitlist.

2. **Care coordination, to include timely assessing children to divert them into community-based services and avoid institutional care where possible, all the way through to engaging children who are in residential facilities in discharge planning to facilitate a timely, safe and successful return home**

   It is apparent to all involved that the highest needs youth desperately need better care coordination. We have traditionally struggled with case management that can work across systems and collaboratively with the teams involved. When it comes to assessments, a common example of what we see in practice is foster youth who did not receive an IDD diagnosis until years too late. Even when on the right track, they languish labeled as "suspicion of IDD" through a long and cumbersome assessment process, all the while excluded from services.

   It often feels like an impossible maze to match just the right diagnosis to an available service, the specific diagnosis often being the reason for a denial from desperately needed help. We believe this accounts for a significant number of children ending up in facilities where it could have been avoided upstream.

Further, care coordination is an impossible task where there is not access to appropriate levels of care across the continuum. Without additional levels of care targeted to populations such as the IDD population, we will never be able to avoid unnecessary escalation or inappropriate step-down placements. We feel strongly that a child cannot succeed if they are discharged from a facility to Child Haven, our system's congregate care emergency short-term stay placement (that is inappropriately and too often not a short-term stay due to lack of placement options). Far too often, we see months or even years of children's lives being spent in locked institutional treatment settings in an effort to get their mental health stabilized, only to become completely disregulated again within weeks or even days of discharge due to stepping down to placements like emergency shelters that are ill-equipped to meet their needs.

3. **Transparency and accountability of the managed care organization, to include clear terms in contracts with the MCO that insure timely access to information, accountability, due process for denials of service, etc.**

   We appreciate the pro-active anticipation to plan for potential pitfalls as requested in question 6. This is our greatest fear in making this transition because of the pitfalls we have experienced with vulnerable populations that we serve in other areas of our practice. . There has historically been a policy decision by the Nevada legislature not to move children in foster care to a managed care model because of their inability to advocate for themselves inside the system and the lack of transparency regarding outcomes. We experienced a lack of accessibility and transparency when the autism population moved to a managed care model and would ask that transparency requirements regarding things like waitlist and utilization are required to be available in real time. Further, information on how to appeal decisions should also be abundantly clear and accessible with shortened timeframes that reflect the urgency of this population to access care. The appeals process must give a meaningful opportunity for reconsideration and not just be a rubber stamp on initial decisions. This complex, vulnerable population needs a system that gets to yes for them instead of finding ways to say no, which is how it often feels now.

4. **Continuity of care that rises to the challenge of this population that faces constant placement disruption**

   We believe that intentional exceptions should be provided to ensure that this population has strong continuity of care. The average foster child can move four times in their first year in care. Access to doctors and services should not be disrupted when everything else in their life is constantly disrupting. Our highest needs youth often move rapidly and frequently between levels of care and must acclimate to different treating professionals with each shift. Better continuity of and coordination of care is needed to promote mental health stability. This includes ensuring that children that are happy with a provider right now are able to maintain that provider through this transition to managed care.

In response to the solicited questions:

1. **Targeted Case Management** – There is no question that it is not currently being done in a way that meets the needs of the population. Irrespective of which agency does the case

management, it needs to be done in a way that is collaborative and reduces the ability to defer responsibility. One single point of contact and responsibility should help reduce the confusion of what level of government is responsible for coordinating what type of service and who should help a child access it. Additionally, ensuring that the key members of the child's support team, who know the child best, are kept informed and able to give input and feedback, will be crucial.

2. **Care Management Approach** – We would advocate for a path that minimizes the variables. If there are layers of entities and/or multiple entities selected to do the same role some may perform differently than others, causing confusion and varied outcomes, and again creating the ability to deflect responsibility to a different layer or party as we often see happen now. If there are multiple CMEs that the SMCP contracts with they should have equal access to the same providers. It will be a challenge to protect the existing established relationships our youth have in cases where they want to maintain those services without disruption.

3. **Benefit Set** – We appreciate the attention to transportation as that is often a major obstacle to care, particularly transportation to Partial Hospitalization Programs and center-based ABA programs. For treatments like these, that often last much of the day, the logistics of the transportation for a caregiver, who is often necessary to accompany the child in transit, is currently an overlooked consideration. Additionally, we share the sentiment that the whole child must be treated and silos must be broken down.. We struggle daily with the lack of integrated programs that can address behavioral health needs alongside IDD needs, or address medical needs in addition to substance abuse needs. Some specific coverage we would like to see expanded includes:
   - Reimbursement for providers (therapist and psychiatrists) to participate in meetings, court hearings, etc. to support care coordination. Coverage for the time the hospital psychiatrist and the outside treating psychiatrist consult, etc.
   - Continuity of care coverage: Currently, if a child is fluctuating in and out of various levels of care, such as acute hospitals and PHP programs, they completely lose access to their regular treating therapist, with whom they may have an excellent rapport - an existing PAR needs to be closed and then a new PAR opened with each move through a level of care, sometimes causing administrative delays in treatment. Our clients would greatly benefit from having access to their primary treating professionals while they are moving through different levels of care.
   - Coverage for mentoring supports and other pro-social activities and supports. This population can be over-saturated with treatment. There are creative ways to get that additional support and structure through other enrichment activities, but funding for such things is a barrier.
   - Expanded and improved respite. Unfortunately, what is currently offered by DRC, for example, does not meet the needs of these families and other respite options are extremely limited. Stability in placements could be increased by offering respite that is at least 6 hours at a time and when needed for emergencies, up to a weekend of coverage. This is particularly important for placements for high needs children with

IDD, who require specialized respite providers adequately trained to meet their unique needs. More robust and independent access to ABA. Regardless of a child's location (detention, acute hospital, residential treatment, ICF, etc.) and what other services they receive (crisis intervention, PSR, BST, etc.) if they qualify for ABA, it should be covered.

- Coverage for lost glasses and other medical items that may be lost. Foster children face numerous and constant placement disruptions and do not have the funds to replace them when lost. They would greatly benefit from having access to a higher number of replacements than the typical population.

4. **Provider Network** – Cost savings should not be a priority for this population; the costs will be incurred elsewhere and tenfold over if these children do not have access to quality treatment. If the current Medicaid rates were sufficient, the provider network would be more robust. Thus, they must be at least the floor rates. There must be incentives and intentionality to support providers to do this well. We support tying additional layers of support to improve outcomes. Additionally, from the youth's perspective some of the things lacking in our current network are diversity, cultural competency, and language accessibility. It is not uncommon for a child with trauma to request a therapist who looks like them, for example, and we are often not able to accommodate those requests.

5. **Collaboration with Child Welfare, Courts, Counties, Schools, and Other Child-Serving Entities** – This is absolutely key. There is not a successful approach if it does not bring the child's team into the process. As the attorney for the child, we need to be involved at the individual child's level of care planning, and we would ask to be included in overall coordination and problem solving for the system as it's developed. If a committee is created we would like to participate.

6. **Solutions to Managed Care Pitfalls** – As mentioned above, we believe there are many lessons to be learned from the transitions other vulnerable populations have made to managed care in our State, the most similar of which would be Autism services. Performance metrics and indicators were not accessible and waitlists were extensive. We would like to have a snapshot of what a child's care consists of going into the transition so we appropriately measure if access changed and if continuity of care was accomplished. It would be incredibly helpful to know how long it took for a child to receive an assessment and be connected with a needed service. We support the utilization and prioritization of non-profit vendors. If it is not feasible to include some of the items suggested above in the benefit package, maybe community reinvestment could be explored as an alternative funding source. While we understand the need to have tools available that promote quality and produce improved outcomes, we are fearful of tools that can be passed down to impact the providers directly. That fear stems from the years

of experience operating in a desert of providers and the need to prioritize recruitment and retention.

Overall, we hope that the desire to provide timely, quality services in an assessable way to all vulnerable children drives the planning and decision making more than anything else. We cannot be afraid of upfront investments for this population if we want to get upstream on these important issues and reduce the need (and thus overall cost) in the long run.

Thank you for your consideration of this feedback. We look forward to future conversations.

Magellan HEALTHCARE®

Response to:

Solicitation of Public Input Regarding the Implementation of a New Specialty Managed Care Plan for Certain Children and Youth Populations

May 23, 2025

Magellan Healthcare Inc.'s Response

1. Targeted Case Management

We support a model like the one used by Washington State. Nevada's Children's Behavioral Health Transformation initiative includes the desire to move toward a standard clinical approach for children, youth, and families with Behavioral Health (BH) issues who are at risk of out-of-home placement statewide. Case management of youth who are in the Child Welfare system can be a critical avenue to introduce some of the highest-risk youth into care. The connections and commitment these case managers have within their communities is important to recognize, especially in an environment where many professionals are leaving the practice of BH behind.

The Division and SMCP should partner on a plan, which could include contracting with the County agencies to become regional CMEs within their home communities. This would ensure that the State's evidence-based approaches are offered and supported by staff who are performing many similar case management activities today. The SMCP can provide the requisite oversight, training, and reporting as required for any other contracted CME within the State; see our response to *Feedback Request #2* for details.

2. Care Management Approach

We recommend a regional CME approach, where regional CME agencies – which have been selected by the SMCP in collaboration with the Division – are contracted to the SMCP, versus the Division procuring these agencies. By having the SMCP serve as the agency responsible for these procurements, the Division will gain the SMCP's experience in overseeing similar programs and delivering accountability to ensure the goals of the Children's Behavioral Health Transformation initiative are being met. Contracting with independent agencies as CMEs promotes sustainability of the program independent of future SMCP selection. Additionally, CME regions should align with the natural geographic regions within the State, allowing CME agency staff to reasonably access the homes or other community-based centers where much of the direct services will be provided. In particular, agencies that bid on CME regions that are rural/frontier should provide their input into the design of these regional borders.

The SMCP should have experience managing a Request for Application or similar process for soliciting and vetting agencies/Providers to perform wraparound facilitation, youth peer support and connection to other key community-based services for youth with high levels of BH need. This process would be done with key approval points by the Division, but the ultimate onboarding, training, coaching and management of the CMEs should fall to the SMCP, with Division oversight. This would create accountability and consistency in clinical practice, operations, data collection and outcomes reporting activities as well as transparency for the State into activities managed by the SMCP.

National experience also proves that Regional CMEs provide more targeted care to the individuals within their communities and provides a faster trajectory to ramping up services to youth and families. This model is used effectively in markets like Ohio, Louisiana, New Jersey, and Idaho, where regional CMEs can provide rapid local access for youth and families with complex BH and multi-system needs. Specifically, Ohio's BH carve-out program for complex youth, RISE (Resilience through Integrated Systems and Excellence), has been using this regional CME model for just over two years, increasing its capacity to serve more than six times the children than it did on day one, and allowing it to quickly expand its network across the State, and add new services and supports for members and families. And, in Louisiana regional CMEs provide outreach to communities that has resulted in near-capacity enrollment in the program and produces a significant number of referrals for services within the community. **Under Louisiana's regional CME model, 70% of youth in wraparound facilitation are receiving additional community based services based on their plan of care.**

3. Benefit Set

We recommend that the State limit the SMCP's funded services to BH. There is *consistent observational evidence* that carve-out managed care plans contain costs and maintain or improve service use for children with serious behavioral conditions. Multiple peer-reviewed analyses (e.g., Burns et al. 1999 in NC 16, Frank & Garfield 2007 review) and government-supported evaluations (Florida, others) found reduced inpatient utilization and spending under carve-outs. The strongest outcome evidence for carve-outs comes from multi-year program evaluations of wraparound approaches (Wraparound Milwaukee, Mental Health Services Program for Youth, and similar System-of-Care initiatives), which consistently show improved functional outcomes (like reduced arrests, better stability) and system outcomes (more community care, fewer institutions) for youth in those programs.

Several states looking to resolve class-action lawsuits and other similar requirements to improve access to community-based care for youth with BH needs are focused on BH-only carveouts. Additionally, experience with established BH-only programs is highly successful nationally. In Idaho, where high-needs children are managed as part of a full BH carveout, **nearly 3,000 youth have been provided community-based care coordination and crisis services in just the first year.**

In Louisiana's BH carve out, nearly 92% of parents/caregivers report they can manage their child's health issues after their tenure in specialized BH services. Ohio's RISE program has shown tremendous scalability, building a base of 18 CMEs, 800 care coordinators, statewide mobile crisis response and stabilization services, and service to more than 37,000 youth in just two years. **Our recommendation is supported by our clinical, network, and financial experience.**

Clinical: When specialty BH services are integrated with primary care services, the management and potential prevention of BH conditions are often lost. Youth and families experiencing Serious Emotional Disturbances (SED) and/or who are multi-system involved with BH issues benefit from receiving targeted interventions including specialized BH services to remain in their communities. A BH-focused SMCP will best understand the management of CMEs that will coordinate these interventions for the youth and within their service area, using trauma-informed principles. **The SMCP's clinical approaches must be supported by a Medical Director who is a Board Certified Child and Adolescent Psychiatrist.**

For youth with SED who are involved in child welfare or juvenile justice, effective coordination between systems is critical. Specialty carve-out programs that are BH-focused will work closely with these systems. Wraparound Milwaukee, for example, is administered by the county child mental health agency in partnership with juvenile justice and child welfare agencies, enabling a single care plan that spans all domains. System-level improvements included a **drop in average daily residential treatment census from 375 to 50 youth**. Similarly, **nearly 80% of high-risk delinquent youth avoided correctional placement** after enrollment in the program, contributing to a **37% decline in commitments in the county and millions in cost savings**.

Network: Children and youth with SED must have a network available that supports their BH needs. This build must be the focus of the SMCP and must include specialized expertise in finding or bringing in Providers who can offer these specialized BH services. Those building the network need to understand the unique challenges that high-intensity BH Providers in Nevada have faced and be capable of implementing a proven process to overcome those. Simultaneously building and credentialling a medical network will detract from this effort.

Members with chronic medical conditions should not be required to change their physical health networks upon entering the SMCP, as this can disrupt care and ongoing support. Chronic care depends on established providers and plans, while BH services are specialized and individualized. Access to both PH and BH networks supports coordinated, comprehensive care, with BH often complementing but not altering medical treatment.

Financial*:* One large physical health claim could dilute resources, compromising the focus on the key BH services required for supporting this vulnerable population. Under an integrated approach, this would take away the SMCP's ability to provide incentives for Providers that create sustainable networks and promote BH initiatives within communities that encourage access to services. Additionally, our experience shows a reluctance of MCOs to refer youth to an SMCP; forfeiting their entire PMPM could increase their reticence to refer youth who require SMCP services.

4. Provider Network

We recommend that the SMCP's network and workforce development efforts support and complement the organizations that are already working to build Nevada's BH workforce. This includes supporting BeHERE Nevada's work to build and sustain the clinical workforce. It also includes supporting those organizations that focus on community health workers and those with lived experience. The SMCP can support the efforts these organizations play in growing the workforce, by providing strong enrollment and sustainable funding for the workforce through Medicaid-funded BH services. The SMCP can also connect organizations in the State to ensure the new workforce has the certifications necessary to provide critical BH services to children, youth and families served through the plan. **We make the following additional recommendations** related to SMCP responsibilities:

Re-engaging Medicaid and Former Medicaid Providers. These Providers are already serving youth in communities across the State and are deeply embedded within the community and have established trusted relationships with youth and families. The SMCP should allocate targeted support for these organizations to serve youth and families needing acute BH services; re-engaging with them will help reintegrate them into the system and minimize future turnover.

A prospective SMCP should demonstrate the **ability to attract new Providers through a targeted, relationship-based approach**, particularly in response to service gaps by type or geographic area. This includes strategies to expand critical services in rural and frontier regions through direct, in-person engagement, assessment of community needs, and sustainable service planning. Leveraging national partnerships to scale services and offering tailored onboarding support can further ease entry for Providers navigating credentialing and regulatory requirements.

The SMCP must collaborate with state divisions to reduce key barriers—such as reimbursement issues and limited clinical support—identified by both the Children's Behavioral Health Transformation Working Group and existing plans in Nevada. Ongoing partnership with the State is essential to implementing short- and long-term strategies that strengthen and grow the Provider network. Bidders should propose proven, effective solutions to support these goals.

To continue to sustain and support a quality workforce, the SMCP should work with the Division to introduce **Alternative Payment Models (APMs)**, as the program stabilizes and collects baseline performance data. This may include bonus payments to reward Providers that achieve quality and outcomes and case rates to simplify billing. Targeted, enhanced reimbursement rate strategies implemented in Nevada have demonstrated measurable success in strengthening the workforce by attracting several national certified provider organizations who had not previously operated in the State. An additional method used successfully in other states includes case rates for a single episode of care. This can help contain overall costs by providing a predictable, bundled payment and incentivizing efficiency and coordination with providers while reducing administrative burdens by simplifying the billing process.

To assist in building, maintaining and training a high-quality BH workforce **we recommend that prospective SMCPs be required to allocate a particular portion of the SMCP budget** for systems grants, implementation assistance, or training, certification and ongoing coaching of Providers who are performing certain evidence-based interventions for youth with acute BH needs. Training and feedback to Providers should include youth and families involved with the system of care, in addition to professional development and coaching to create sustainable conditions for long-term participation.

We see no cons to honoring the current fee schedule; it is appropriate to create a reimbursement floor, allowing the SMCP to appropriately manage the quality of the services delivered by Providers. However, **we recommend that the Division consider a specialized fee schedule for this program** and include enhanced responsibilities for collaborating on care. This would limit the SMCP's financial risk and be more enticing to providers; without them, Providers may tend to focus on service volumes versus quality and outcomes.

As an alternative, **we recommend that the Division consider allowing the SMCP to implement supplemental payment options** that work in conjunction with the fee schedule such as bundled payments, PMPM payments, or stipends. This approach would maintain the Medicaid fee schedule as the minimum payment standard while allowing for flexible payment enhancements that address workforce challenges, Provider capacity, and access gaps. It ensures the system remains responsive to the needs of Nevada's Providers and the vulnerable populations they serve.

5. Collaboration with Child Welfare, Courts, Counties, Schools, and Other Child-Serving Entities

Nevada's communities are peppered with high-quality individuals, organizations, and programs for youth with complex diagnoses and with multi-system involvement, but they are not often known outside of their local communities. **We recommend** that the SMCP **build collaborative partnerships** with the divisions of state government and with key community-based organizations that provide services to youth in the target population.

The success of specialty children's mental health is dependent upon cross-sector collaboration that serves the child/youth and the whole family, as well as the other agencies, departments, and communities that are part of the vital support system for a child, youth, and family. **We recommend** that a prospective SMCP demonstrate prior success in helping states build this collaborative environment through the following mechanisms:

- **Managing permission-based access roles to sensitive data, based on the youth's or family's wishes**.
- **Accessing and using data-sharing platforms, protocols and processes that allow for transparency, when appropriate, across state and community agencies**. For instance, the SMCP should show the ability to connect with statewide platforms or data exchanges.
- **Developing a partner portal that child-serving agencies who are part of the Child and Family and/or Treatment Team can use to access** youth- and family- specific data, such as their Provider and case manager contact information, assessment, treatment plan, and updates from the team.
- **Documenting successful approaches and outcomes at the member and aggregate levels** relating to cross-functional collaboration and case review for youth with multi-system involvement or for youth with multiple diagnoses.
- **Establishing and maintaining partnership relationships with state and County collaboration partners**, which allow for ongoing referrals, handoffs to community resources upon youth graduation from Wraparound Facilitation. Experience here should include working with entities such as Medicaid physical health MCOs, DFCS, family courts, Office of Juvenile Justice, the Department of Education, crisis system partners, and emergency departments to define written collaborative protocols.

Magellan recommends forming a statewide SMCP Coordinating Committee comprised of youth, their caregivers, and cross-sector collaboration partners. The committee should have a clearly defined scope, include representation from across the State, and include child-serving agencies as well as representative youth and families. This committee would establish a mechanism for data sharing, for transparency and accountability from the SMCP to the partners, and also for transparency and accountability from the partners to the SMCP. It would allow each agency to identify barriers that keep it from doing its best work in communities and with the target population. In regard to escalation for non-performance, **we recommend** that the State and the SMCP create an escalation path that allows for transparent reporting of issues, while allowing the SMCP sufficient time to respond appropriately to address, investigate or remediate any issues.

Finally, **we recommend** that the SMCP build on the efforts of existing workgroups such as the Children's Mental Health Workgroup, and the various Children's Mental Health Consortia across the State. These groups should be strategically aligned to their respective purpose, and cross-pollinate data, emerging trends, and voice of youth and families with feedback loops back to the SMCP to maximize alignment and impact. **We further recommend** that the SMCP have a single point of contact for the coordination of these groups.

6. Solutions to Managed Care Pitfalls

a. Performance

We recommend that the Division build upon the success of the public dashboard for its Medicaid program and the current reporting requirements of the Case Management Entity. Metrics which report enrollment trends, referral trends, authorizations and claims are objectively appropriate, enabling the Division to consistently track and report across all its programs. A public-facing dashboard for tracking performance and other measures of the SMCP and its Providers will be a source of performance tracking, as well as serve an information source for those seeking to refer youth and families for services. Suggested quality metrics include:

- Caseload by regional CME, including open slot information;
- Demographics of youth involved in various levels of wraparound facilitation and by region/County;
- Source of referral, including by region;
- Involvement of caseload in service categories, including wraparound facilitation, peer support and respite services;
- Youth, family, and Provider satisfaction scores (updated annually); and,
- Graduation rates by region, age, or other demographics.

It is also important to consider data quality and validation needs as the program launches and stabilizes. It is advisable to avoid 'managing to metrics' until the program matures and the data quality is validated.

b. Profit v. Non-Profit

The legal structure of an organization will not inherently determine the quality of care or cost-effectiveness of the SMCP. Either type of organization can be held accountable to contractual and fiscal obligations. It is more important that the State selects the partner with the correct clinical experience, collaborative approaches, and outcomes for similar populations, to ensure success with the new SMCP. Furthermore, the MLR requirements for the SMCP will remain the same regardless of legal status. However, a for-profit SMCP reinvests in communities through tax dollars in ways such as supporting schools, law enforcement and other institutions that will be an integral part of the backdrop and support for services that are rendered through this plan.

c. Vendor Payment

Requiring a Medical Loss Ratio (MLR) is an expected approach based on federal accountability. Along these lines, **we make the following recommendations:**

- A minimum MLR of 85%, which aligns with federal standards for Medicaid MCOs and Medicare Advantage plans. This benchmark reflects a sustainable balance between funding direct care services and allowing sufficient resources for innovation and efficient administrative operations.
- Decisions on how any annual additional payments are allocated should be the result of a collaborative dialogue between the SMCP and the Division. We recommend these funds be directed toward further program development including expansion of services, as these investments typically yield the greatest return in terms of care quality and service delivery.

Offering Additional Bonus Payments to Providers or for the SMCP: Our experience demonstrates that Providers are highly responsive to incentivized payment programs. To be effective, **we recommend aligning bonus payments to the intended outcomes of the program** such as a Provider's timely acceptance of referrals and engagement with youth, high member satisfaction, superior access and availability, serving high-need or underserved/specialty populations including non-English speaking members and rural families, and overall reductions in risk score as measured by a standardized tool such as the CANS assessment.

We further recommend that the SMCP should have the opportunity to earn incentives, too. However, SMCP incentives should align with the intended outcomes and impact of the program; examples include implementing online training

platforms and a care management system—both funded by the SMCP—to directly support Providers. These efforts aim to boost utilization of outpatient services and expand both the availability and use of network providers in rural areas. By offering additional incentives for achieving the intended outcomes, the Division positively motivates the SMCP to perform while still including financial accountability should it fail to do so via the Quality Withhold Payment. These two mechanisms can work together to the Division's benefit, achieving its stated goals.

d. Community Reinvestment

We recommend that the SMCP pre-tax reinvestment rate be equivalent to that required of the State's MCOs, and that reinvestment requirements align with the goals of health system transformation. Examples include:

- Funding technical assistance and outreach to encourage key non-participating Providers to join Medicaid and the SMCP network, as needed to expand appropriate service levels across the State.
- Providing advanced training in specialty BH, including wraparound, timely comprehensive care coordination plans, targeted case management, complex trauma, the CANS assessment etc.
- Funding community outreach, education, and engagement to raise awareness about the SMCP plan and services; this includes sponsoring and exhibiting at community events, radio, social media, news, print advertisements, etc.
- Reimbursing caregivers for transportation to appointments.
- Promoting after-hours care that increases appointment availability for working youth and caregivers.
- Introducing telehealth hubs in rural communities to strengthen access.

e. Quality Withhold Payments

To ensure the success of the quality program, **we recommend that the quality metrics be clear, measurable, achievable, defined in advance, and agreed upon by both parties**. These measures should evolve over time, reflecting the maturity of the program, and focusing first on process, then fidelity, and finally, outcomes. There must be transparency from both parties on how performance will be tracked and evaluated; timely reporting and feedback from the Division to allow for course correction, if needed; and a fair opportunity to earn back the full withhold if targets are met or exceeded within the performance period. These metrics should be aligned with fidelity metrics, and processes and outcomes sought by the Division, which could include enrollment targets, process metrics on timeliness, and clinical outcomes, such as overall reduction in out-of-home placements.

MEMORANDUM

To: Nevada Division of Health Care Financing and Policy (DHCFP)

Date: May 23, 2025

Subject: **Solicitation of Public Input Regarding the Implementation of a New SpecialtyManaged Care Plan for Certain Children and Youth Populations**

FirstMed Health and Wellness (FirstMed) is Nevada's only "GOLD" certified Federally Qualified Health Center (FQHC) and is currently the sole medical provider to Clark County Department of Family Services (DFS)'s "Child Haven" in southern Nevada. Through this relationship with DFS, FirstMed is receiving c.125+ rereferrals a month for comprehensive mental health services to youth in foster care (in Clark County). In 2024, FirstMed provided over 37,000 individual encounters for medical, therapy and psychiatry at our 4 locations in Clark County. Of these, over 60% were treated for mental health issues, with 22% (of that 60%) being youth in the foster care system. FirstMed works with all 4 MCOs in Clark County; some are better than others, although we have real concerns that the business model that drives the profitability in the MCO setting is contrary to a robust and rewarding system of care for foster care generally, and more specifically for youth outlined in this RFI. We are hoping for the opportunity of "management of care" rather than "Managed Care" and we outline our comments below.

In an FQHC setting today, medical, therapy and psychiatry in an outpatient setting are already providing strong results for FirstMed and we submit, DFS. Adding the next step in care, but still in an outpatient setting would be a Partial Hospitalization Program (PHP) which is currently within the scope of FirstMed and will be the next step in outpatient care for foster youth in Clark County. We have a payment model that supports this work, although acknowledge the limitations for higher levels of care. Moving to an exclusive MCO-type care model risks alienating the current population of case workers in DFS and Clark County Juvenile Justice (CCJJ) who have dedicated careers to work towards improving outcomes. We also fear that the current MCOs will present a bevy of "programs" and "services" with faux best-practices (with only internal citations) that will ask too much of the foster family and, or case workers under the auspices of "innovation". We also have concerns if MCO contracts allow an over-leverage to the MCO and does not create parity to the provider/FQHC.

Given the 5 examples presented in this RFI, FirstMed would advocate for number 2, Care Management Approach, with the Care Management Entities (CME), being cross walked to FQHCs and a methodology that supports the FQHC encounter rates for services currently not covered, i.e.: case management, care coordination, transportation, etc.

We would also like to see CME's working with current case workers in Clark County and other like structures across the state. Revenue shares should be considered on a cost+ 20% basis, (unless a federal indirect rate has been approved). We feel this is important so that the jurisdiction has some financial remedy for the cost of carrying the case workers, driven by the FQHC, under a provider agreement between the FQHC and the jurisdictions, perhaps even a tri-party agreement between the FQHC/jurisdiction/MCO.

FirstMed would also encourage DHCFP to develop an adaptive contract with an MCO that calls upon their expertise and access to specialists, and hospitals, but allows FQHCs/FirstMed to remain in the lead on day to day care, without invasive "provider reviews" and payment garnishment that is exclusively driven by the MCO without remedy to the FQHCs and the federal commitment to maintain care. Within the realm of current MCOs, FirstMed's position is that Silver Summit is the market leader MCO in southern Nevada. Silver Summit is a strong collaborative partner, and while there may be different approaches between FirstMed and Silver Summit, a mutually beneficial outcome is always achieved. We would like to see this same level of professionalism migrate to this SMCP, allowing FirstMed to maintain and grow in already proven areas and the MCO to provide higher levels of care, including but not limited to hospitalization and specialized foster care, subject to caveats noted above. Additionally, FirstMed acknowledge that cost for medication can be high. As such FirstMed (and all FQHCs) could use their 340B purchasing power to drive down costs to the consumer.

As noted, FirstMed has a strong presence and working relationship with southern Nevada's foster care population. We worked towards this relationship over the past 6 years and feel very strongly that the work that we do, the relationship that we have established with DFS, the foster families and the youth we serve, is critical to any ongoing success with the population and should be protected throughout the next steps over the coming months. Maintaining these trusting relationships in paramount to the existing system of care. And while this system is bifurcated, it is critically important to acknowledge that progress is being made. Today's system is better than it was 5 years ago, although there is room for improvement. However, this improvement must no come at the cost of DFS case workers or the foster families who work daily to improve the lives of youth in their care. Alienating foster families; drag them across the valley for some ad-hoc "centers of excellence" will not improve outcomes for youth. FirstMed, working closely with DFS, is proving that access that is neighborhood based at our 4 clinic locations, and includes additional programming such as trainings with Community Health Workers, or tailored group therapy for foster families, again, in the communities they live. This is far more impactful and valuable to the foster family and by extension, the system as a whole.

In the end, if a performance piece is designed because of assumptions and "one stop" depots of service, it will not succeed and Nevada's kids in care – all who are in care, not of their own choosing – will be left behind. DHCFP is the right entity to lead this initiative, and FirstMed has confidence in their willingness to hear from the constituents that make up the foster care and juvenile justice system, and to ultimately develop an RFP/RFQ that will draw a straight line from these constituents to the group and, or groups that will ultimately be selected to lead improving outcomes for Nevada's high risk and high need youth, and the case workers and foster families who support them.

FirstMed acknowledges DHCFP's commitment to improving outcomes and reducing the institutionalization of youth in the state and to deliver results that are both quantifiable and quality measured. We are in full-throated agreement on this and look forward to supporting this work in any way possible.

Our thanks again for this opportunity to present our concerns and shared opportunity.

Input Regarding the Implementation of a New Specialty Managed Care Plan for Certain Children and Youth Populations

Response to item # 4

To ensure the long-term sustainability of Nevada's behavioral health infrastructure and to effectively address persistent workforce shortages, service gaps, and low provider participation in Medicaid, we recommend the implementation of a **behavioral health capitation model**—particularly for levels of care 1 through 4.

The primary reason many behavioral health providers abstain from enrolling in Nevada Medicaid is due to **reimbursement rates that are insufficient to cover the administrative and clinical costs** associated with delivering care. Providers must meet extensive documentation, compliance, and prior authorization requirements that are labor-intensive and often unreimbursed. The administrative burden, when coupled with the low fee-for-service (FFS) rates, makes participation financially unfeasible—especially for small and mid-size practices, community nonprofits, and agencies serving high-need youth populations such as those with autism, intellectual/developmental disabilities (IDD), or co-occurring disorders.

A **capitated payment model**—where providers are paid a fixed per-member-per-month (PMPM) rate to deliver a defined set of services—offers several benefits over the current fee-for-service approach:

1. **Predictable Revenue Supports Sustainability**
   Providers gain **financial predictability and stability**, enabling them to hire and retain staff, build service capacity, and invest in training and infrastructure without relying on unpredictable billing cycles.
2. **Reduces Administrative Waste**
   Capitation minimizes **billing complexity, claim denials, and back-end audits**, freeing up provider resources for direct care rather than paperwork and compliance overhead.
3. **Encourages Holistic and Preventive Care**
   With an assigned panel of youth and families, providers are **incentivized to invest in early intervention, family support, and preventative services**—rather than waiting for crisis-level reimbursement triggers under FFS.
4. **Supports Integration and Continuity of Care**
   Capitation allows behavioral health organizations—both nonprofit and for-profit—to **strategically coordinate services across levels of care** , reducing fragmentation and unnecessary out-of-state placements.
5. **Builds a Resilient Provider Network**
   With guaranteed monthly payments and enrolled populations, provider organizations are better positioned to **scale operations, participate in training programs, and build the clinical workforce Nevada desperately needs.**
6. **Aligns with Value-Based Care**
   A capitated structure can be paired with **quality incentives or outcome-based bonuses** to reward high-performing providers and drive equity-focused, evidence-based care across the state.

To maximize continuity of care and resource accountability, we recommend that under the State Medicaid Capitated Program (SMCP), youth be **assigned to a primary behavioral health provider** based on geography, specialization (e.g., IDD, autism), and provider capacity. These providers would then be accountable for delivering or coordinating all services within levels of care, supported by PMPM capitation payments.

The current Medicaid fee-for-service model is neither equitable nor sustainable. A **capitated behavioral health structure**—tailored to youth needs and implemented through both nonprofit and for-profit partners—would **strengthen Nevada's provider infrastructure**, improve health outcomes, and deliver long-term cost efficiency for the state.

Response to Solicitation of Public Input Regarding the Implementation of a New Specialty Managed Care Plan for Certain Children and Youth Populations

Submitted to:
Nevada Division of Health Care Financing and Policy
ChildrensBH@dhcfp.nv.gov
Due by May 23, 2025, at 11:59 PM PST

May 22, 2025

Nevada Division of Health Care Financing and Policy
ChildrensBH@dhcfp.nv.gov

RE: Solicitation of Public Input Regarding the Implementation of a New Specialty Managed Care Plan for Certain Children and Youth Populations

Thank you for the opportunity to provide public input on the State's development of a Specialty Managed Care Plan (SMCP) to support the delivery of Medicaid covered services to children with behavioral health needs. On the following pages, Molina Healthcare of Nevada, Inc. (Molina), submits a response to all six questions included in the Solicitation of Public Input.

We appreciate the opportunity to provide this input and look forward to our ongoing partnership with the State as it continues to develop the new SMCP. As you will see throughout our responses to the individual questions, Molina believes a strong partnership among all stakeholders in this solution—e.g., the health plan, State agencies, and providers—will be critical to the success of the program in the state of Nevada.

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1. Targeted Case Management

Given our experience and lessons learned from our affiliates, Molina Healthcare of Nevada, Inc. (Molina) recommends the Division directly finance targeted case management with a fixed bundled rate and use a Specialty Managed Care Plan (SMCP) as an intermediary between government agencies.

Best Practices and Lessons Learned Implementing Targeted Case Management

Through our experience and that of our affiliates in implementing programs with targeted case management, we recognize that having an MCO manage, coordinate, and pay directly for services is a best practice approach that helps track and eliminate the risk of duplicative payments while ensuring timely payments. This approach simplifies outcome data and analysis tracking and presents opportunities to implement value-based care that drives improvement in health outcomes and helps achieve sustainability. We encourage the Division to allow the SMCP to either provide targeted case management or subcontract these services. Based on lessons learned, we also recommend the Division consider the following best practices as part of its solution:

- **Sole source, statewide contract.** Based on the experiences of our Washington and Ohio affiliates, we recommend a sole source contract for an SMCP to provide statewide services to avoid duplication of services, funds, and case management activities. Lessons learned from our affiliate in Washington include the importance of identifying fragmented care—such as when members in foster care move across county lines and require multiple handoffs between systems—while also addressing challenges related to continuity of care and reducing the risk of traumatization. A sole source, statewide contract avoids such fragmentation, as there is no need to develop new systems of care when a member moves into another county.
- **Monthly meetings.** We recommend the Division hosts monthly meetings with the SMCP and other entities involved in targeted case management to collaborate and streamline processes, including tracking care management interactions, performance metrics, and information sharing capabilities. For example, our Washington affiliate worked collaboratively with the state and other care management and case management entities to identify duplication in initial assessments and worked to develop a process flow that eliminated this duplication. Routine touchpoints may reduce duplication of care management outreach, visits, and services.
- **Funding of clarity meetings.** Since funding for serving children with complex behavioral health needs comes from multiple budgets and sources, we recommend monthly (at a minimum) meetings with the Division and the SMCP to ensure there is no duplication in targeted case management payment made thought the SMCP that should be paid for through Title IV-E dollars or McKinney-Vento funding.
- **Information sharing.** We recommend the Division collaborate with the SMCP to create data sharing standards and requirements to encourage and monitor information sharing across Medicaid program health plans and system partners. For example, Molina and our affiliates have experienced challenges receiving pertinent information (e.g., demographic data and care plans) from other health plans when members transfer to our plans. Schools and child services agencies may fail to share key information, such as Individualized Education Plan or care plans. We encourage the Division to monitor data sharing performance metrics, such as outstanding requests for information, and that monetary penalties be included for entities involved in the member's care for failure to provide information to the SMCP.
- **Clear delineation of roles.** We recommend the Division provide clear guidance on the delineation of targeted case management and contractual care management functions. For example, our Washington affiliate's best practices include collaborating across all entities providing targeted case management and care management services to clearly define the roles and responsibilities of each

organization. This clarification has helped to ensure safety and permanency supports to members, including during transitions of care and significant events.

- **Outcomes-based care.** To drive successful outcomes rather than volume of services, we recommend the Division partner closely with the SMCP to hold providers accountable for delivering appropriate services using quality metrics focused on outcomes. We recommend the Division link reimbursement with outcome metrics on quality goals relative to symptomology, admissions, or needs over time, such as: Follow-Up After Hospitalization for Mental Illness (FUH), Follow-Up After Emergency Department Visit for Mental Illness (FUM), Follow-Up After High-Intensity Care for Substance Use Disorder (FUI), Follow-Up After Emergency Department Visit for Substance Abuse (FUA), Follow-Up Care for Children Prescribed ADHD Medication (ADD), Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM), or Initiation and Engagement of Substance Use Disorder Treatment (IET) HEDIS measures, as well as additional measures, such as cholesterol and blood sugar testing for youth on antipsychotic medications and diabetes screening for individuals with schizophrenia or bipolar disorder. For example, our Illinois affiliate has successfully tracked outcome measures such as FUH, FUA, and FUM in their post-crisis program for members under age 21.
- **Member engagement requirements.** We recommend the Division follow the best practice of implementing requirements for the frequency of face-to-face meetings as part of targeted case management, similar to the High Fidelity Wraparound approach used in Washington. The SMCP would be responsible for overseeing and maintaining targeted case management providers' compliance with contract requirements. We also recommend the Division implement member outreach and engagement requirements during a transition of care or after an acute care event.

2. Care Management Approach

As a trusted partner to the Division, we make our recommendations based on our local experience in Nevada combined with that of our affiliates in other states.

Recommending SMCP-led Care Management Services

To encourage locally based, whole-child care for members that is family-driven and tailored for youth, **we recommend the Division use SMCP-led care management services with the option to delegate to a Care Management Entity (CME) when it is in the best interest of the member.** SMCPs have the experience and expertise to connect, coordinate, and oversee care management in alignment with contractual requirements while ensuring a High Fidelity Wraparound system of care. Although they may be experienced in providing targeted case management, many CMEs cannot currently meet Medicaid contractual requirements. In addition to achieving contractual compliance, we recommend the Division use SMCP-led care management services to ensure:

- **Whole-child care.** This model encourages better continuity of care and collaboration across organizations.
- **Locally based care.** SMCPs have existing relationships with members, with others in the community, and with the State.
- **Continuity of care.** SMCPs can manage and be responsible for all aspects of care management and can have visibility into all the services and supports that members receive.
- **Use of proven systems.** SMCPs have established pricing, coding, and billing models and have the capabilities to build relationships and support organizations to provide care management services.

If delegating some or all care management services to a CME, we recommend that SMCPs have flexibility in payment methodology to create alternative payment models supported by the State, such as offering incentives for CMEs that will provide care in rural areas or for specialty populations.

Best Practices to Provide Care Management for Children with Specialty Care Needs

We recommend the Division consider the following best practices and lessons learned when implementing care management services through an SMCP or CME:

- **Contract-specific caseload.** We recommend the Division add contractual limits on care management caseloads for this population.
- **Engagement requirements.** We recommend the Division implement requirements for the frequency of in-person care management visits using an approach similar to the High Fidelity Wraparound strategy used in Washington. The SMCP would be responsible for ensuring care management compliance with contractual requirements. We also recommend the Division implement member engagement requirements during a transition of care or after an acute care event.
- **Information sharing.** We recommend the Division work collaboratively with the SMCP to create data sharing standards and requirements for the SMCP and other entities involved in members' care. These standards will help reduce inefficiencies related to entering data manually and ensure continuity of care through practices such as working collaboratively to establish and maintain a shared care plan.
- **Covered diagnoses included in the benefit set.** We recommend that in addition to IDD, serious emotional disturbance (SED), serious mental illness (SMI), and substance use disorder (SUD), the Division consider adding all diagnoses requiring an Individualized Education Plan—such as autism, developmental delays, cerebral palsy, and non-ambulatory conditions—to the benefit set and deem them as eligible for care management services, particularly when there are co-occurring conditions.

3. Benefit Set

To ensure the whole-child approach to care is achievable, our benefit set recommendations are intended to remove silos in current systems.

Best Practices in Implementing a Whole-child Approach to Integrated Care

As a part of the benefit set, we recommend the following:

- **Partnership with the SMCP.** We recommend the Division partner closely with the SMCP to determine and modify the benefit set as needed to integrate services for this population. As a best practice learned from our Washington affiliate, co-designing program components with the SMCP and the Division will help create a High Fidelity Wraparound approach that reduces administrative burden for monitoring and claims while including high-intensity, in-home, evidence-based practices; peer support services; and telehealth options.
- **Covered diagnoses included in the benefit set.** We recommend that in addition to IDD, SED, SMI, and SUD, the Division consider adding all diagnoses requiring an Individualized Education Plan—such as autism, developmental delays, cerebral palsy, or non-ambulatory conditions—to the benefit set.
- **Whole-child benefit set.** As a best practice learned from our affiliates implementing targeted case management programs across the country, we recommend the Division include current Medicaid covered services (e.g., crisis services, mobile crisis, inpatient mental health, and treatment for children and youth with IDD/autism and behavioral health needs, including Applied Behavior Analysis [ABA]), as well as in-home services, peer support, residential and specialized residential treatment (including out-of-state placements), respite care (both acute and crisis respite), telehealth supports (to augment care), and community-based day treatment. We further recommend the Division consider the following benefits for inclusion:
  - **Dental.** We encourage the Division to consider carving in dental services to support whole-child care. A dental carve-in offers the Division several advantages, including reduced costs, ceded insurance risk, and decreased need for program management. Members and their providers will benefit from streamlined administration, enhanced engagement, and increased integration with physical health service delivery to ensure comprehensive and coordinated care, promoting better oral health and overall wellness.
  - **Transportation.** We recommend the Division carve in non-emergency medical transportation statewide, including transport for siblings or other family members. To improve access to transportation services for members, we recommend the Division consider enhanced reimbursement rates, incentive programs to serve rural areas, and mileage reimbursement at federal rates for family and friends using personal vehicles.
  - **Flex funds.** We recommend the Division allow flex funds to fill gaps in services. As a best practice, the OhioRISE program uses primary flex funds to enhance and supplement available services, increase safety in the home, and decrease state-provided services. These funds could be used in combination with social determinants of health (SDOH) funds for supportive housing for the member and their family to further promote whole-child services.
  - **SDOH.** As a best practice, states across the country are using waivers to add SDOH services as covered benefits, rather than using value-added or In Lieu of Services. For example, Massachusetts received CMS approval to add nutrition support as a flexible services program; North Carolina is piloting a program to add food support and meal delivery; Oregon has added housing and nutrition as covered services; California has added enhanced care management, housing supports, and activity stipends for individuals with or at risk of behavioral health conditions; Hawaii approved food and nutrition supports earlier this year; and Washington has a proposed plan to add nutrition as a covered benefit.

4. Provider Network

We offer the following recommendations for the Division to consider while building and maintaining a provider network to serve children and youth with specialty behavioral health needs.

Best Practices to Build, Maintain, and Train a Quality Workforce and Reduce Gaps

To build, maintain, and train a high-quality workforce, reduce service gaps, and address systemic provider shortages to serve the complex needs of this population will require a strong partnership between the Division and the SMCP to bring providers to the State. We recommend the following approaches—based on best practices and lessons learned across Molina affiliates coordinating with their state partners—to support the SMCP in creating a successful network by:

- **Developing new and additional in-state treatment options.** We recommend the Division explore alternative opportunities to develop and expand in-state residential treatment facility capacity to reduce the need for out-of-state placements, which may include building new facilities and enhancing service provision in existing ones. Our Florida affiliate partnered with the Florida Coalition for Children's Learning Collaborative to train behavioral health providers in increased system capacity and expanded treatment options for children and families through billable evidence-based practices.
- **Establishing in-state options for higher levels of care.** We recommend the Division develop in-state options for children who require a higher level of care. This approach includes collaboration with behavioral health providers, PCPs, ancillary clinical and support services, SDOH resources, and schools to create a comprehensive whole-child support system as members transition through levels of care.
- **Integrating telehealth.** We recommend the Division allow SMCPs and providers to use telehealth in alignment with the 2026 Medicaid contract (including reimbursement for audio-only telehealth), in particular to serve children and youth in rural areas. For example, our Washington affiliate is successfully serving children through their Virtual Intensive Engagement Wraparound program, our Arizona affiliate provides telehealth services for this population in rural areas, and our Florida affiliate provides telehealth covered services for a similar population. We recommend the Division allow foreign licensure for telehealth providers to address access issues and bridge gaps in care.
- **Investing in technology.** We recommend the Division invest in telehealth and teleconsultation services to bridge access gaps, especially in rural areas.
- **Enhancing regulatory flexibility.** We recommend the Division update regulations to allow professionals to practice at the top of their licenses and enable task shifting where appropriate. This fosters collaboration across the workforce and improves access to high-quality care. We recommend identifying trainees and interns eligible for reimbursement as Qualified Mental Health Professionals (with supervision) to enhance access to services, such as for psychology intern credentialing.
- **Developing the behavioral health workforce.** We recommend the Division support the expansion of entry-level behavioral health positions to increase access to community care, acute services (which will have higher utilization with this population, such as the need for respite and mobile crisis services), and specialized services such as ABA. For example, the Division may:
  - **Supporting certification programs to improve the non-licensed workforce.** Certification programs for community health workers and peer support specialists help to standardize training and quality of care. As a best practice in Arizona, FQHCs or other behavioral health providers sponsor hands-on training during an internship-like process that can fast-track employment.
  - **Designing financial incentives.** Incentive programs such as loan repayment and sign-on bonuses may attract and retain providers, and can be offered to encourage providers to support members in specific geographic regions (e.g., in rural areas or locations that lack providers).
- **Funding training.** We recommend the Division designate funding for training programs, continuing education, and partnerships with academic institutions for providers serving SMCP children and

youth. To support the screening and monitoring of non-behavioral health providers who are supporting children and youth with high-acuity pediatric behavioral health diagnoses and crisis situations, we encourage targeted training on measurement-based assessments and alignment with behavioral health providers. For behavioral health providers, we recommend complex diagnoses and treatment modality training, so children can continue their specialized treatment.

- **Supporting caregivers and families.** We recognize that caregivers, whether formal or informal, need additional support to care for this population. The Division should consider working collaboratively with the SMCP to provide education and training, support caregivers. For example, our Washington affiliate works collaboratively with the state to provide ABA training for parents and caregivers.
- **Mapping roles and functions.** We encourage the Division to map roles and responsibilities across the licensed and non-licensed workforce to optimize team-based care models. This effort can include mapping roles based on their importance and limiting the scope of providers who require supervision and the cadence of supervision to ensure appropriate oversight and care delegation. This approach can strengthen care coordination and leverage the full potential of the behavioral health workforce that ensures contracting with mid-levels and extenders.
- **Developing specialized centers.** We recommend the Division develop specialized centers focused on the treatment of children and youth with IDD/autism to provide targeted and effective care, which may include integrating support with PCPs and FQHCs where possible and assisting in expanding Certified Community Behavioral Health Centers (CCBHCs). For example, our Florida affiliate partners with a behavioral health HUB that is led by local universities that are offering case consultation by psychologists and psychiatrists. Our Arizona affiliate has Center of Excellence partnerships with multiple specialty providers that support needs like those related to SUD and autism and that serve individuals, such as those who are justice involved and transition-age youth.
- **Providing legislative recommendations.** We recommend the Division encourage the Nevada Legislature, the Governor's Office, or other State agencies to support the expansion of respite care services, including strategies to increase awareness of respite care services and their benefits.
- **Gathering data and providing analysis.** We recommend the Division implement a data system to track the number of children with SED sent out of state and assess the ability of SMCPs to provide necessary care in Nevada.
- **Setting appropriate rates for meeting complex behavioral health needs.** Similar to the OhioRISE program, we recommend the Division consider building in quarterly review periods with the SMCP to ensure that reimbursement rates are appropriate and cover the costs of the program. These reviews will help the Division calculate costs to support the DOJ settlement and allow the SMCP to compensate providers so that they can continue to serve this vulnerable population.
- **Implementing an episodes of care model.** Tennessee Medicaid's episodes of care program bundles payments for all services related to a specific condition or treatment over a defined period. We recommend the Division implement a similar model to encourage providers to deliver efficient, high-quality care and reduce unnecessary variations in treatment.

The Current Fee Schedule for Reimbursement

We support the Division using a fee schedule that helps attract providers to the State and allows the SMCP to pay providers appropriate rates, as noted in the DOJ settlement. Aligning fee schedules across Medicaid programs reduces administrative burden on providers.

5. Collaboration with Child Welfare, Courts, Counties, Schools, and Other Child-Serving Entities

To ensure effective cross-sector collaboration and partnership with child welfare, court systems, juvenile justice, counties, school systems, and other child-serving entities, we recommend the following requirements and best practices.

Standardizing and Streamlining Data and Information Sharing

We agree with the Division's goal of improving data and information sharing, and further recommend aligning shared systems, technologies, and processes across multiple entities through the following methods:

- **Comprehensive data sharing agreements.** We recommend the Division establish clear data sharing agreements among all participating entities, such as the NDE and DCFS, to facilitate the seamless exchange of information using a central aggregator and remove barriers to systems interoperability, such as through use of the health information exchange. This type of data sharing will aid in real-time decision-making and provide a holistic view of each member's needs and services.
- **Integrated technology platforms.** We recommend the Division adopt integrated technology platforms that enable interoperability across different systems. This approach will ensure that data from various sources, such as child welfare, schools, and healthcare providers, can be easily accessed and used.
- **Standardized processes and protocols.** We recommend the Division develop standardized processes and protocols for service delivery and information sharing. Uniform guidelines, as well as shared screenings and assessments, will streamline efforts and minimize discrepancies in care and support provided to children and youth.
- **Simplified administrative practices.** We recommend pricing consistency with fewer consolidated, provider-specific rate cells and with straightforward benefits standardization, which will simplify how the Division maintains benefits, pricing, and oversight, and increase program savings for the State and the SMCP. Offering narrow rate cells will benefit the Division as it is expanding managed care into new regions by standardizing incentive and bonus payments, since they are calculated using the same baseline figures.
- **Simplified documentation.** We recommend the Division streamline and align documentation, including Medicaid Services Manual chapters, fee schedules, web announcements, provider-type billing guides, monthly files with prior authorization and provider-specific rates, and email clarifications. Inconsistency across these various sources can lead to errors, questions, inconsistent benefit application, and the need to spend considerable time researching and confirming the Division's guidance and requirements.

Collaborating and Ensuring Transparency with Child-serving Community Partners

To support collaboration and ensure transparency with child-serving community partners, we recommend the Division consider the following measures:

- **Regular communication channels.** We recommend the Division create dedicated communication channels for regular updates and exchange of feedback among all stakeholders.
- **Performance metrics and reporting.** We recommend the Division establish clear performance metrics and reporting mechanisms to ensure accountability and continuous service enhancements. Further, we recommend that these metrics and reporting mechanisms be the same for physical health and behavioral health to ensure mental health parity as well as to track progress and identify areas for growth, such as access to community-based high-intensity services, reduction in wait times, or improvement in crisis care metrics.

- **Public reporting of performance.** We recommend the Division implement a system for public reporting of SMCP performance metrics and outcomes to build trust among partner entities and the community.
- **Regular cross-sector training.** We recommend the Division implement ongoing cross-sector training programs for all staff involved in the system of care. This training will enhance each sector's understanding of their roles and responsibilities and aid in the dissemination of best practices, fostering a culture of collaboration.

Implementing an SMCP Coordinating Committee

We support and encourage the establishment of a family-driven and youth-guided SMCP coordinating committee comprising regional representatives from various child and youth systems, as well as family representatives. Further, we recommend this committee be chaired by a member of the Division, responsible for meeting its goals. This committee would serve as a valuable advisory body that ensures that the voices of all stakeholders, including families, are heard and considered in decision-making processes to support culturally competent and relevant care. We suggest this committee make recommendations about the information that can and should be shared across entities. To understand the needs of child and youth members with specialty needs, we further recommend this committee collect and analyze local, community, and statewide data. To support the coordinating committee and how SMCPs deliver services, we also recommend establishing an operative collaborative and an advisory collaborative, as described below.

Operative Collaborative. We recommend the Division encourage participation in this collaborative that should include key stakeholders from SMCPs, law enforcement, mobile crisis teams, associated government agencies and departments, clinical and administrative entities, and larger treatment facilities and groups. The roles and responsibilities of this group should include developing, implementing, and maintaining identified workflows and initiatives, such as those related to discharge planning, data and information sharing, growth and development of systems of care, and care planning; monitoring ongoing performance and resolving issues; and managing acute situations or those involving members with complex needs.

Advisory Collaborative. We recommend the Division encourage participation in this collaborative that should include key stakeholders from the operative collaborative, community partners and organizations, peers with lived experience, and members and their families or legally authorized representatives. The roles and responsibilities of this group should include soliciting feedback about programs, experiences, and needs; identifying new or underutilized resources; and planning for further system growth and development.

6. Solutions to Managed Care Pitfalls

To avoid managed care pitfalls, we recommend that the Division consider the following feedback regarding performance, profit vs. non-profit, vendor payment, community reinvestment, and quality withhold payments.

a. Performance

In alignment with other Medicaid programs and services, we recommend the Division consider adopting widely used and well-known performance metrics such as HEDIS, key performance indicators, member or provider satisfaction surveys such as CAHPS, and any metrics used for NCQA reporting. While states require MCOs to provide public links to EQRO and CMS mandated quality oversight, some states (such as California, Arizona, Illinois, Texas, and Washington) have collected and reported this information on a single site. Other states, such as Iowa[1] and Louisiana[2], provide an interactive dashboard that displays performance metrics with graphics and is sortable by program, population, and subpopulation.

b. Profit v. Nonprofit

We recommend the Division offer contracts to the most qualified organizations that can best meet contractual obligations and serve as trusted partners rather than prioritizing selection based on nonprofit or for-profit status. While nonprofit status allows for multiple favorable tax benefits, we encourage the Division to pursue transparency into all parts of SMCPs, such as the profit-based operating units of their businesses and how they compensate their staff. We view the integrity and service delivery capabilities of an SMCP to be the primary qualifications to serve this vulnerable population, with the tax filing status (for-profit vs. nonprofit) not having an impact on how the business entity provides care to members.

c. Vendor Payment

We recommend the Division implement a similar MLR standard for the SMCP delivery system as it has for the Medicaid program, with the understanding of and accounting for higher administrative costs for this vulnerable population. We further recommend the Division offer this contract to an SMCP with demonstrated experience and can offer expertise and recommendations for an MLR that is appropriate for the future SMCP populations and services offered, once finalized.

d. Community Reinvestment

We recommend the Division implement a community reinvestment program for the SMCP delivery system that is similar to its Medicaid managed care program.

e. Quality Withhold Payments

We do not recommend a withhold arrangement for payment, as it challenges actuarial soundness, in particular at the beginning of a new program. We recommend the Division use a bonus payment program for SMCPs that is similar to that used for the Medicaid managed care program, which has demonstrated success increasing PCP utilization. We also recommend the Division adopt widely used

[1] Iowa Health & Human Services, *Medicaid Performance and Reports*, https://hhs.iowa.gov/performance-and-reports/medicaid-reports, 2025, accessed May 17, 2025.

[2] Louisiana Department of Health, *Healthy Louisiana: LDH Medicaid Managed Care Quality Dashboard*, https://qualitydashboard.ldh.la.gov/, accessed May 17, 2025.

and well-known quality metrics to ensure a level playing field by measuring service utilization and health outcomes against national and local benchmarks. We recommend these performance measures be specific to this population and that the Division work in collaboration with the SMCP to determine which metrics demonstrate successful outcomes. To drive better performance and outcomes, we recommend additional bonus payment structures and systems for SMCPs.

Public Comment: Implementation of a Specialty Managed Care Plan (SMCP) for Children with Behavioral Health Needs

Submitted by: NAMI Nevada, NAMI Northern Nevada, NAMI Western Nevada, & NAMI Southern Nevada
May 23, 2025

As affiliates of the National Alliance on Mental Illness (NAMI), NAMI Nevada, NAMI Northern Nevada, NAMI Western Nevada, and NAMI Southern Nevada (referred to as NAMI Nevada affiliates) provide community-based mental health services and advocacy for individuals living with mental health conditions and their families. We appreciate the opportunity to submit public comment regarding the development of Nevada's new Specialty Managed Care Plan (SMCP) and offer the following insights and recommendations, with particular emphasis on peer support, youth and family engagement, and system coordination.

1. Provider Network & Youth Peer Support Services

One of the most urgent needs in Nevada's behavioral health continuum is the development of a sustainable, culturally competent provider network that includes certified peer support specialists. NAMI Nevada affiliates have launched an authentic Youth Peer Support Services pilot program statewide, a growing initiative designed to empower youth with lived experience to serve as mentors and advocates for their peers. We recommend that the SMCP:

- Include Certified Youth Peer Support Specialists (YPSS) as reimbursable providers under Medicaid and ensure their integration in multidisciplinary care teams.
- Promote the co-location of peer services within schools, juvenile justice systems, and community-based settings to improve accessibility and reduce stigma.
- Offer reimbursement incentives for peer-run organizations and providers that employ YPSS and demonstrate successful engagement and retention outcomes.

Peer support, particularly for youth, is an evidence-based service that reduces emergency room visits, improves care coordination, and strengthens treatment adherence. Youth are more likely to engage in services when supported by someone with shared experience, particularly in crisis and transitional periods such as discharge from residential care.

2. Care Management Approach & Family Voice

NAMI Nevada affiliates recommend adopting a Care Management Entity (CME) model that leverages organizations with strong community roots and experience navigating complex systems. We propose that:

- CMEs include family and youth peer navigators as essential care team members and as a core unit in the development of the system.

- The SMCP provide training and certification pathways for family and youth peer supporters, ensuring a pipeline of skilled and representative personnel.
- Regional CMEs be embedded within existing community-based nonprofits and organizations to foster trust and ensure culturally responsive care.

3. Community Reinvestment and Value-Added Services

As part of community reinvestment efforts, NAMI Nevada affiliates encourages the Division to require SMCP vendors to support the expansion of peer-led educational programs and others of the like such as:

- Ending the Silence - A classroom-based program teaching students about mental health awareness and suicide prevention.
- Family-to-Family and Basics - Evidence-based education programs for caregivers of youth with behavioral health needs.

These programs, while not Medicaid-reimbursable, significantly improve outcomes by equipping families and youth with knowledge and tools to navigate the mental health system. Community reinvestment funds should also be allocated toward:

- Transportation support for families attending mental health appointments.
- Digital equity initiatives that ensure access to telehealth for low-income or rural families.

4. Collaboration with Child-Serving Systems

NAMI Nevada affiliates emphasize that cross-sector collaboration is most effective when formalized and funded. To ensure accountability and alignment:

- The SMCP should participate in a cross-system Community Advisory Committee such as the Clark County Children's Mental Health Consortium with mandated representation from family members, youth, education, child welfare, and juvenile justice.
- Support shared data systems or data-sharing agreements to track outcomes and support real-time coordination across agencies.
- Mandate standardized training across systems on trauma-informed care, youth engagement, and system navigation, with peer-run organizations involved in curriculum development.

5. Solutions to Managed Care Pitfalls

NAMI Nevada affiliates support the implementation of a public performance dashboard including metrics such as:

- Time to service access post-referral.

- Utilization of peer support and family engagement services.
- Reduction in inpatient psychiatric admissions.
- Client and family satisfaction ratings.

We also support:

- A Medical Loss Ratio (MLR) of at least 85%, to prioritize funding toward service delivery.
- Prioritization of non-profit entities or hybrid models with demonstrated community investment and transparency.
- Quality withhold payments tied to engagement, continuity of care, and reduced institutionalization rates.

Conclusion

The implementation of a Specialty Managed Care Plan for children with behavioral health needs offers an opportunity to fundamentally strengthen Nevada's system of care. NAMI Nevada affiliates and its Youth Peer Support Services stand ready to partner in this transformation. We urge the Division to embed peer support, family engagement, and community-based leadership into the core design of the SMCP.

Date Thu 5/22/2025 11:21 AM

To Children's Behavioral Health <ChildrensBH@nvha.nv.gov>

To Whom It May Concern,

Thank you for the opportunity to provide feedback on the development of a Specialty Managed Care Plan for children with behavioral health needs in Nevada. As a nonprofit organization exclusively serving kinship caregivers across the state, Foster Kinship is deeply invested in how Medicaid continues to support children living outside of the traditional foster care system, particularly those in informal kinship care.

Nevada has approximately 30,000 children living in kinship care—being raised by relatives or close family friends rather than their biological parents. Of these, over 28,000 are outside of the formal foster care system. These children have almost identical needs to those in foster care, especially in the areas of trauma recovery, mental health support, and behavioral health interventions. However, they do not have access to the same suite of supports and services simply because their caregivers stepped up informally.

Last year alone, Foster Kinship served over 3,200 of these families. Nearly every child we support is either enrolled in or eligible for Medicaid HMO plans, and for many, it's their only access point to medical and behavioral health services. Children in informal kinship care often face high rates of trauma, emotional instability, and behavioral challenges, but without state involvement, they are at risk of being overlooked and accessing the same supports that Fee-for-Service Medicaid presently offers kids in foster care.

A Specialty Managed Care Plan must intentionally include this population and recognize that their needs mirror children in foster care. If behavioral health supports are not designed to include informal kinship families, we risk creating a two-tiered systemin which children with equal or greater needs are excluded simply because their family stepped up to care for them without court involvement.

We strongly urge Nevada Medicaid to:

1. **Ensure coverage protections** for children in informal kinship care remain intact, are robust, and are elevated to meet the behavioral health needs of children in kinship care outside of the foster care system.
2. **Provide flexible eligibility pathways** to behavioral health services and support that do not require formal foster care involvement.

3. **Include kinship-specific service providers** who understand the unique family structures and needs in the plan design.

4. **Develop streamlined reimbursement models** that enable trusted community-based organizations to deliver and be reimbursed for behavioral health support services, without burdensome or duplicative state administrative requirements that delay care.

If informal kin caregivers lose Medicaid or access to behavioral health supports for the children they care for, it will drive more children into the foster care system unnecessarily, precisely the outcome the kinship care model seeks to prevent.

We would welcome further discussion or participation in planning sessions to ensure the voices of kinship families are heard.
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Hello, I am responding to the RFI titled: Solicitation of Public Input Regarding the Implementation of a New Specialty Managed Care Plan for Certain Children and Youth Populations

Connect Our Kids is a 501c3 nonprofit that provides tools and trainings to help Medicaid providers, child welfare professionals and others to support the mental, emotional, and relational health of child welfare affected (or at risk) children and families. We are currently working with the Medicaid provider in another state to get foster children connected to family members so that they can leave high-cost residential care facilities.

Addressing Item 3, Benefit Set: With regard to the "whole-child" approach and "what would be most valuable to supporting the care and needs of this child population and their families and/or caregivers":
Relational health — the strength of one's supportive meaningful relationships — is foundational to all other health, but is often overlooked because it can be invisible. We recommend that relational health be explicitly centered in Nevada's Medicaid approach for the child populations of interest. This can be done by requiring that Medicaid case managers and relevant providers are always attentive to the important relationships in the member's life, and how those relationships are impacting their current challenges. Connect Our Kids (https://connectourkids.org/) provides training on the importance of relationships, and provides tools to support the awareness, safeguarding, and growth of those relationships. This is a particularly devastating issue in the context of foster care, where children and families can have their relationships severed, causing great harm to all involved. Connect Our Kids helps keep those relationships intact, preferably with families staying physically together, but also and especially if children must be temporarily cared for outside their own home.
Multiple studies have shown that, other than in the most extreme cases of abuse, children do best with their own imperfect parents, and if out-of-home care does become necessary, children in kinship placements are more likely to express satisfaction with their placement and graduate from high school, and less likely to exhibit difficult or dangerous behaviors, run away or be trafficked, and ten times less likely to be re-abused. A study of siblings separated, with one sibling taken into foster care, and another sibling who stayed with biological parents, found that the siblings raised in foster care had twice the rate of attempted or completed suicides.
Medicaid is crucial to this issue, as Medicaid can be the driver for the supports that allow families to stay together when they are struggling and child safety becomes a concern. Connect Our Kids is focused on this issue.

Addressing Item 5, Collaboration with Child Welfare, Courts, Counties, Schools, and Other Child-Serving Entities: Connect Our Kids has experience working in states and collaborating with multiple child-serving entities. Acknowledging the collaboration challenges already

noted in this Solicitation, we also recommend that Nevada also consider that the collaboration challenges go both ways. The SMCP may be ready and willing to collaborate, but the other party may not feel a need to do so lacking some driver to prioritize this collaborative effort. Anything that Nevada can do from the state level to increase the collaboration from both directions will help enormously. The ideas of SMCP coordinating and community advisory committees are good ones.
From the perspective of selecting an SMCP, we recommend that an important criteria for selection be a demonstrated eagerness to collaborate, especially with innovative mission-driven companies in this space. Evaluation of these mission-driven companies should also include assessment of their eagerness to collaborate. Some to look at, in addition to Connect Our Kids (https://connectourkids.org/), are Your Case Plan (https://www.yourcaseplan.com/), Psyche Care (https://www.psychecare.org/), Peers.net (https://peers.net/) and HereNow Health (https://www.herenow.health/). There are great ideas at work in the small business space, and you have the exciting opportunity to tap into these to allow Nevada to leap forward in providing high-quality support to your vulnerable populations.

Addressing Item 6, Solutions to Managed Care Pitfalls:
b. Profit vs. Non-profit. Rather than this dichotomy, we recommend that Nevada carefully consider each company on an individual basis, based on their demonstrated commitment to the values of interest to Nevada in this contract, and select those that clearly share the mission and values of this effort to improves the lives and outcomes for Nevada's most vulnerable.
c. Vendor Payment. While acknowledging that this can be a complicated space, we would like to raise the concern that medical loss ratios can cripple efforts to implement beneficial and innovative scalable solutions that aren't appropriate for individual reimbursement codes.

Thank you for the opportunity to give input on this decision. I am available for any follow-up questions you may have.

Dear State Development of a Managed Care Plan

I am writing to express the urgent need for increased support and resources for behavioral health services. Access to comprehensive and timely care is essential for individuals facing mental health challenges, ensuring their well-being, stability, and ability to thrive in their communities.

The need to access to professional care, community support programs, workplace and school resources, crisis prevention & intervention, and equity and accessibility.

Investing in behavioral health not only improves individual lives but strengthens families and communities. Expanded resources, equitable access, and improved policies can make a meaningful difference in ensuring effective and compassionate care.

I respectfully urge SMCP to prioritize behavioral health needs by increasing funding policy changes, community base initiatives, education and awareness, and equitable access and crisis intervention services. I appreciate your time and commitment to addressing this crucial issue, and I am hopeful that together, we can make a lasting impact.

Thank you for your consideration. Please feel free to contact me if you require any additional information.

Dear Nevada Division of Health ,

I am a single mother of two children, both of whom suffer from serious mental health challenges. I am reaching out to urgently advocate for meaningful reform within the Medicaid system, particularly regarding mental and behavioral health services for children and families.

My Family's Story

My daughter is a survivor of sexual assault by a peer at school. As a result, she experiences chronic migraines, anxiety, and PTSD. Despite having a 504 plan, she was forced to remain in the same school as her abuser, where she endured threats and harassment—while her trauma responses were met with punishment rather than support. Only after significant advocacy and access to trauma-specific therapy funded through Sexual assault victim programs did she begin to heal. Today, she is preparing to graduate and tells her story to others who have experienced the same—a testament to her strength and the power of appropriate care.

My son, who has an IEP, is diagnosed with high-functioning autism, major depression, mood disorder, anxiety, and PTSD. He has been admitted to multiple residential behavioral health facilities across different states and even mistreated by some. Accessing appropriate care has required an overwhelming number of calls, emails, grievances, and even state complaints—just to get him the services he needs and is legally entitled to. He was misunderstood by school staff and overlooked until he was finally hospitalized for suicidal ideation.

Had my son been given access to the community-based, comprehensive, and family-centered supports outlined below, there is a very real chance he would be home with me today—instead of being placed in yet another residential facility.

Critical Areas for Reform

1. Expand Medicaid Coverage to Include Trauma-Informed and Diverse Therapies

Medicaid must cover a broader range of therapies to meet diverse mental health needs, including:

Trauma-informed therapy

- EMDR (Eye Movement Desensitization and Reprocessing)
- Hypnotherapy
- EMBP (Emotionally Based Mental Health Programming), particularly for children and teens experiencing severe depression, anxiety, or emotional dysregulation

- Experiential and creative therapies such as art, music, animal and movement therapy
- **EMBP (Electro Magnetic Brain Pulse) Look up Epic Brain Centers In Reno NV.**
- Medicaid should also support family-strengthening activities like monthly outings, which build coping skills and reinforce healthy relationships.
- Include experiential and individualized therapeutic options tailored to a child's needs.

2. Trust Clinical Judgment Over Cost-Driven Decisions

- Care decisions should be made by the child's treating providers—not cost-saving consultants who have never met the child or family.

3. Streamline Prior Authorizations

- Expedite authorizations and reduce documentation burdens that delay care.
- Approvals should be based on medical necessity as determined by licensed professionals, with decisions returned in days—not weeks.

4. Improve Residential Treatment Standards

- Require residential centers to offer:
    - Frequent one-on-one therapy and individualized treatment.
    - Accredited, district-connected education with certified teachers.
    - Access to general health services (vision, dental, physical check-ups).
    - Secure parent portals for daily updates, academic tracking, and provider communication.
    - Daily family phone/video calls and more frequent off-site visitation.

5. Ensure Family Involvement and Support

- Fund monthly in-person visits for out-of-state placements—including siblings.
- Provide peer support programs for both youth and parents.
- Create communication tools such as secure apps and private messaging platforms to connect families with providers and each other.

6. Strengthen Case Management Independence

- Case managers should advocate for the child's full needs—not only what Medicaid will cover.
- Include multiple professionals (psychologists, educators, primary care doctors) in care decisions—not rely solely on psychiatrists.

7. Prioritize Keeping Children Safely at Home

- Expand comprehensive, community-based services including:
    - Frequent outpatient therapy (individual, group, family)
    - Mobile crisis response units
    - Peer and parent support
    - In-home safety planning and suicide prevention training
    - Wraparound coordination and respite care
    - Suicide watch services while parents work or attend to family needs

8. Increase Provider Participation by Reforming Medicaid Practices

- Raise reimbursement rates to make Medicaid participation financially viable.
- Pay providers on a timely basis.
- Simplify authorization processes and reduce excessive paperwork requirements.

9. Build Accessible, Coordinated Care Infrastructure

- Implement secure communication platforms for providers, schools, case managers, and families to coordinate care in real time.
- Offer free transportation to IOP/PHP programs.
- Provide home-based educational supports (internet, computers, printers) for children unable to attend school due to mental health.

10. Improve School-Based Mental Health Support

- Make mental health education mandatory in schools.
- Train school staff to recognize and respond to signs of mental health crises.
- Ensure students are not penalized for absences due to therapy or medical needs.
- Embed mental health professionals directly into school systems.

11. Foster Youth-Specific and Financial Supports

- Assign mental health advocates to children in foster care.
- Create a paid caregiver program for parents providing full-time care for children with significant mental health needs.
- Offer monthly incentives to children adhering to treatment plans (e.g., small gift cards).
- Provide access to drug testing and support services for families.

If my son had access to these supports earlier, his trajectory could have been drastically different. He might still be home with me—surrounded by love, healing, and stability.

If you would like **specific examples, documentation, or supporting stories**, I would be more than happy to provide them.

Thank you for your time, consideration, and dedication to creating a better future for our children and families. Our mental health system must do more—and Medicaid reform is the essential first step.

Clark County response to Soliciation of Public Input Regarding the Implementation of a New Specialty Managed Care Plan for Certain Children and Youth Populations.

The Nevada Division of Health Care Financing and Policy (DHCFP) requested public comments and feedback to inform the State's development of a Specialty Managed Care Plan (SMCP). The SMCP would support the delivery of Medicaid covered services to children who have behavioral disabilities to reduce reliance on institutional and congregate care. This includes the expansion of certain community-based services and new investments in Medicaid reimbursement for qualified providers.

On January 2, 2025, the State of Nevada reached an agreement with the Department of Justice (DOJ) to ensure that services, programs, and activities offered by the State to children in the Focus Population will be provided in the most integrated setting appropriate to meet the needs of children and their families.

The Focus Population in the Agreement is defined as a Medicaid-eligible Child who has Behavioral Health Disability; and is in a hospital or Residential Treatment Facility; or is eligible for or at risk of being placed in a hospital or residential treatment facility; or receives Mobile crises response & stabilization services 3 or more times within a 12-month period.

Clark Couty is a major stakeholder in this endeavor as approximately 70% of Nevada's population resides in Clark County. The Focus Population identified in the Agreement between the State of Nevada and the U.S. Department of Justice (DOJ) to expand state-funded community-based services and establish a SMCP is a substantial subset of the populations served by Clark County Department of Family Services and Clark County Department of Juvenile Justice Services.

Clark County has concern that the Solicitation of Public input expands the Focus Population and is proposing to mandate children and youth ages 0 – 21, who meet one of the following criteria, to enroll in the SMCP for case management services:

1. SED or SMI and/or co-occurring condition/disorder such as an intellectual development disability or substance use disorder.
2. Involved with the foster care system; and
3. Determined to be at high risk of developing SED or SMI.

The expansion of the Focus Population from the Agreement to the proposed population in the Soliciation of Public Input increases the population to basically all Medicaid eligible children and youth that Clark County Family Services (CCFS) and Juvenile Justice Services (JJS) serve. CCFS and JJS are ultimately responsible for and are required to manage these two populations regardless of their Medicaid eligibility. The Departments will continue to be responsible for assessing and ensuring service provision to this population as well as

providing case management services regardless of the development and implementation of an SMCP.

Clark County has concerns about sharing this responsibility for Medicaid only children with a managed care plan as each entity may have different and/or competing goals. This will impose a bifurcated system for the County as it relates to the populations served (Medicaid vs non-Medicaid). It will also duplicate services as Clark County will always be responsible for managing these two populations to some degree.

Furthermore, Medicaid passes on the federal share of Medicaid's costs for Targeted Case Management (TCM) services to Clark County utilizing Certified Public Expenditures (CPE) for the State's share of Medicaid costs. Clark County is concerned that this initiative will put the passthrough of these federal funds in jeopardy and will increase the State's general fund costs for case management services as currently, Clark and Washoe counties pay the State's share of TCM billable services within their county.

Clark County has found these children are screened and assessed by different staff and entities. These children are referred to services; however, the bigger concern is provider capacity and availability of mental and behavioral health providers needed for intensive outpatient treatment, children and adolescents with co-occurring disorders, specialized assessment such as neuro-psychological evaluations, assessment for Fetal Alcohol Spectrum disorder, and services for the intellectually and developmentally delayed population on demand, to divert these children from congregate care so they may remain in a community setting placement.

Please see our comments below:

1. Targeted Case Management: Although the State of Nevada has a bifurcated approach to case management based on region, case management for this population is provided by the government entity responsible for the welfare of these children. The Agency's responsibility to manage and oversee the welfare of these youths cannot be separated and parceled out to another entity. Per DHCFP Policy, there can be two case managers if the youth is included in more than one target group and is eligible to receive case management services from a different program. If this occurs, a Lead Case Manager is assigned and is responsible for coordinating the additional case management services and for ensuring the elimination of any potential for a duplication of service.

   Currently, the Targeted Case Management (TCM) service and the child welfare population are both a carve out from the Managed Care Organization Program. TCM is considered a medical service, not an administrative service. The federal share of the local government provider's cost is passed onto the local government responsible for the welfare of the youth at the Federal Medical Assistance

Percentage (FMAP) rate. The state's share is provided by the local government provider through Certification of Public Expenditures (CPE).

The Division is requesting comments on the different approaches proposed to ensure stability of the current case management system and financing of case management through Medicaid for the new SMCP. The example in the Solicitation of Public comment is for the local government provider to continue providing case management as a network provider for the MCO Plan. The MCO Plan will pay the network provider, which is the local government entity who is providing the case management service. The payment from the MCO Plan will be at a rate negotiated between the MCO Plan and the network provider. We believe this will increase Medicaid costs since the MCO Plan will be paid a capitated payment from Medicaid, then pay the local government provider the State and Federal share of the negotiated rate. We do not see the benefit to this approach as nothing would change other than how the funds would flow. The MCO Plan would get a portion of the Medicaid payment, and the local government entity may not be able to negotiate a rate that pays at least the federal share of the County's cost to provide the service that is needed to sustain the current funding level.

The County must provide management and oversite of this population as required by other governing regulations such as IV-E. As such, Clark County staff will continue to provide case management even if an SMCP is implemented. This will create duplication of services and a bifurcated system within Clark County since not all youths are eligible for Medicaid.

As mentioned in the opening general response, the focus population in the agreement is a subset of the child welfare and JJS populations. The Medicaid Agency is proposing broadening the population to all "at risk" youths. All the youth served by CCFS and most all served by JJS are "at risk" of developing behavioral health and/or substance use disorder.

We believe the problem does not stem from case management of this population but rather, from the capacity of direct service providers that provide intense outpatient treatment and the other aforementioned services on demand. Clark County has experienced up to a 3 week wait time to get a child and their family into services needed to allow the child to remain in a community setting rather than be admitted into an inpatient and/or residential treatment setting. For highly specialized services, such as assessment for fetal alcohol spectrum disorder that wait is measured by years, not months.

Clark County would suggest a pilot of this program done in the rural areas of Nevada first, where case management and services may be lacking. Clark County is requesting to opt out of enrolling our youth in an SMCP that includes TCM until such time there are quantifiable results to evaluate the benefit(s).

2. Care Management Approach: A Care Management approach is a great concept and works well for chronic illnesses. Our understanding is Care Management provides certain case management for medical needs but excludes the social and educational needs that TCM provides for this population. A good Care Management program relies on good communication and access to health records. Strong cross-system coordination would also be critical. This allows providers to efficiently identify the services needed while reducing duplication of services. We do see the need to share data as the child welfare and JJS populations can be assessed many times over again by different entities; these records are not always shared with other providers. Clark County would also request that peer support/family partners be included in the care management process.

   Clark County is supportive of an initiative for electronic health records as we are responsible for, and currently paying contracted vendors, to provide medical and mental health care to this population while in detention/correctional facilities and often while in shelter care or foster homes.

   The case management outlined in this section appears to be focused on ensuring access to care management for behavioral health needs but does not address the lack of service providers or waiting times to access behavioral health care and other medical services. It is also unclear how it will be handled if the county case manager or clinical team believes a service is necessary, but it is denied by the care management entity. Information on a dispute resolution process is requested.

   We do not understand the different proposals for how the Care Management entity will be structured or how it would improve care.

3. Benefit Set: A SMCP delivery system to integrate medical care, hospital services, pharmacy, behavioral health and transportation may address concerns about access to immediate care for this population if the SMCP does not restrict their provider network and/or can demonstrate they have a sufficient provider network.

   If the SMCP is paid to provide these services, will the SMCP providers be required to provide services within the Child Haven Campus and JJS Detention Centers? If not, there would be a duplication of payment for these services as Medicaid will pay the SMCP for services that are provided by Clark County's medical vendor under contract while the child is in custody or at the Child Haven Campus. Many community-based services rely on familial involvement for their success. While Clark County understands, values and encourages familial participation in treatment interventions, this is not always a reality for youth served particularly in

the child welfare system. Will there be services or interventions available for youth who may not have engaged family members?

The benefit set of a SMCP would be welcomed if TCM remains carved out and is not considered a duplication of services and if the SMCP is required to provide services at the child haven campus and detention centers. It is well-known that there is a lack of service availability in the community. Will the SMCP have a concerted plan and effort to develop service array and expand availability for the complex populations that will need to be served?

It is also unclear about how the SMCP would impact funding for services for youth in foster care who are placed in specialized foster care. Because specialized foster care is funded through a mix of local child welfare and state Medicaid funds, there is concern about whether the specialized foster care (SFC) providers could continue to provide and bill for services delivered to youth in specialized foster care settings. Clarification on whether the SFC providers would need to enroll with the MCO in order to bill for services is requested.

4. Provider Network: Clark County strongly agrees Nevada's behavioral health care continuum requires expansion and sees firsthand the behavioral health workforce shortage. Clark County was awarded several grants for the expansion of mental health services. Several other initiatives have been implemented recently to address this issue.

   Recently, Clark County created an office specific to provision of clinical services for children and youth involved in the county systems. All qualified in-house staff and service provider contracts will be housed and managed in the new clinical office. Staff qualified as mental health service providers will transition from overseeing case management for the most difficult cases to providing direct behavioral health services to this population as needed. The Department is currently undergoing a review to identify Medicaid billable services and determine the best provider type(s) to enroll as.

   Because the Medicaid rate is not sufficient, Clark County must contract directly with several behavioral and mental health providers to provide direct services to this population. Requiring the SMCP to honor the Medicaid Fee Schedule rates for the higher-level mental health providers is often not sufficient. Rates for services frequently used by children and youth in the identified population should all be evaluated for potential rate increases where needed.

5. Collaboration with Child Welfare, Courts, Counties, Schools, and Other-Serving Entities.

Clark County welcomes any collaboration efforts and shared systems to better serve this population. We are open to examining the best practices and working with other entities to improve the health and care of the youth and families. Including additional services such as mobile crisis, youth peer support, and telehealth would be additional beneficial services.

6. Solutions to Managed Care Pitfalls:

Clark County does not have much experience in dealing with managed care plans from this perspective. However, we submit the following recommendations for 6.d:

6.d Community Reinvestment. If there is a requirement for the Managed Care entity to provide profit sharing, Clark County would like to see reinvestment into preventing homelessness within the community and reinvestment to support the recruitment and retention of foster parents. These are important issues to address barriers to placement in a community setting rather than congregate care.

There is no other input for this section, thank you for the opportunity to provide public comment for this large and important endeavor.

Response to the Request for Information for the Implementation of a New Specialty Managed Care Plan for Certain Children and Youth Populations

The Nevada Division of Health Care Financing and Policy (DHCFP)
Email: ChildrensBH@dhcfp.nv.gov

Response Deadline: May 23, 2025 | 11:59 PM PST

1. TARGETED CASE MANAGEMENT

The Division is seeking feedback on this model and any best practices or lessons learned from similar approaches to integrating a SMCP (or managed care model) into a locally administered case management service model in a manner that continues to support (if not improve or strengthen) the local administration of these services if that is desired outcome by the locality. The goal is to bolster the current system for these services, not supplant them unless the current case management entity prefers that the SMPC take on the case management role.

Please limit feedback to no more than 1-2 pages for this item.

Response:

SilverSummit Healthplan (SilverSummit) is grateful for this opportunity to submit feedback about Nevada's new Specialty Managed Care Plan (SMCP) for children and youth meeting eligibility criteria in the Settlement Agreement. SilverSummit's Nevada Medicaid experience and the experience of our affiliate health plans with sole-source SMCPs for foster care in six states inform our recommendations.

We recommend that DHCFP limit eligible SMCP bidders to those with experience as a Nevada Medicaid managed care plan and experience providing health insurance statewide in Nevada. SMCPs with Nevada experience bring a deep understanding of the health care system and the challenges and opportunities in urban, rural, and frontier areas. DHCFP can also consider preferential scoring for bidders with demonstrated experience serving SMCP populations. Bidders with SMCP experience serving populations listed in the Settlement Agreement understand how to coordinate care for all Members and which Members will benefit from Targeted Case Management (TCM) services. By focusing on bidders' experience, DHCFP will ensure competitive bids from qualified SMCPs committed to supporting this transformative journey for Settlement Agreement Members, families, and Providers to meet State goals.

RECOMMENDATIONS FOR INTEGRATING TCM

To inform recommendations regarding TCM, we relied on DHCFP's current definition of TCM, a service that helps youth in eligible populations access essential resources like medical, social, and educational services. We assume that TCM Providers will continue to provide assessments, service planning and coordination, advocacy, and monitoring for Members of the SMCP.

We agree with DHCFP that Washington State's hybrid model fits Nevada. The hybrid approach will ensure the SMCP provides care coordination, including TCM through community-based Providers, for all Members without duplicating expenses or existing TCM resources. As the first and only SMCP for Washington State's foster care program, we know this model works. Since 2016, our Washington affiliate has served children and youth in foster care, those in adoption support, young adults in extended foster care (ages 18-21), young adults who aged out of foster care (ages 18-26), those reunified with their parents (for 12 months after foster care ends), and unaccompanied refugee minors. With 21,000 current Members, we know how to build the hybrid model and deliver results. In 2024, we achieved:

- A 3 out of 3-star rating for satisfaction of care provided to children, from the Washington State Healthcare Authority

- The highest rate in the nation for the Follow-up After Emergency Department Visit for Mental Illness HEDIS measure, meaning more children and youth in foster care in Washington receive the necessary follow-up care more than anywhere else in the country

We will use lessons learned from Washington and our long-standing relationships with TCM partners in Nevada to build a collaborative, aligned system of care in partnership with Clark County, Washoe County, and the Division of Children & Family Services (DCFS). We will break down siloes across TCM entities, school systems, Providers, and other key stakeholders.

We want to support the existing TCM system and honor TCM case managers' vital role and experience within Clark County, Washoe County, and the counties served by DCFS. ***We recommend that DHCFP require the SMCP to execute contracts with existing TCM Providers to:***

- Honor the current system of care, trained Nevada workforce, and the TCM services that work now
- Create system stability and cohesiveness to benefit youth and families currently served by TCM Providers
- Simplify administrative processes for DHCFP
- Reduce duplication of efforts and payment by having one payment system of record

The SMCP will have contracts with Clark and Washoe Counties and DCFS, and contracts will require claim submission for TCM services. We understand claim submission will be new for these agencies and will provide all the support necessary to make this a successful transition. DHCFP will then be able to monitor TCM service provision through the encounter submittal process. The SMCP will serve as the single source of truth by providing DHCFP with TCM reporting required by the Settlement Agreement. Additionally, by submitting claims, TCM Providers will receive Medicaid funds to promote the financial stability of the existing system of care and reduce duplication.

2. CARE MANAGEMENT APPROACH

The Division seeks information on recommended best practices for care management and feedback on the best approach to ensuring quality care management services are available statewide for this child population with the implementation of a new SMCP.

Please limit feedback to no more than one page for this item.

Response:

RECOMMENDATIONS FOR QUALITY CARE MANAGEMENT FOR CHILDREN AND FAMILIES

We recommend that DHCFP take the approach described below to ensure all SMCP Members receive care coordination services tailored to their needs. Our recommendations assume the SMCP will be responsible for overall care coordination responsibilities, determine the level of care coordination a Member receives, and provide intensive care coordination services. We recommend that Care Management Entities (CMEs) provide High-Fidelity Wraparound services and that general case management remains with the SMCP. High-Fidelity Wraparound is intensive, evidence-based, team-based, and family-centered case management for youth with

complex behavioral health (BH) needs, often involving multiple systems. We recommend the following:

- ***DHCFP procures CME Providers to create a network of qualified Providers across Nevada.*** This approach will build a statewide, community-based system of CMEs to provide High-Fidelity Wraparound services across Nevada. A State procurement process will allow DHCFP to mandate the standard of care for CMEs, ensure a consistent system across Nevada, and ensure CMEs support Members and the community regardless of which managed care plan is the SMCP. In our experience, CMEs work best when they are rooted in the community and serve as the backbone for collaboration among systems and Providers that support youth with complex BH needs. Services provided by the CME can also help prevent youth with complex BH needs from entering the child welfare and juvenile justice systems. DHCFP should require CMEs to include SMCP care coordination staff on the wraparound team to ensure each Member receives whole-person health care.
- ***DHCFP procures CME Providers on a regional basis with sustainable reimbursement.*** We recommend that DHCFP procure CME Providers regionally with the capacity to serve the number of youth and families in need of High-Fidelity Wraparound in the assigned region. DHCFP should annually adjust High-Fidelity Wraparound enrollment targets based on analysis of the SMCP population needs and Provider capacity. We recommend that reimbursement for High-Fidelity Wraparound covers the cost of delivering the service, ongoing staff training, and fidelity monitoring.
- ***DHCFP requires the SMCP to contract with all State-selected CME Providers.*** Since the SMCP is responsible for all care coordination, contracting with CMEs will allow oversight of Members in CME services. Including CMEs in the SMCP Provider network will enable the SMCP to create the required reporting to comply with the Settlement Agreement. By billing the SMCP for High-Fidelity Wraparound services, CMEs can build financial stability. Billing the SMCP also reduces the likelihood of duplicate payments from Medicaid funds.
- ***DHCFP requires the SMCP to offer care coordination services to every Member.*** The SMCP should provide care coordination to every Member, with the intensity and modality of care coordination determined by risk stratification. The SMCP should oversee all care coordination, whether provided by the SMCP or through TCM and CME Providers.

3. BENEFIT SET

The Division seeks feedback on this approach and any best practices or lessons learned about implementing an integrated benefit set for this population. The Division also seeks input on the types of value-added benefits (outside of the Medicaid-covered benefits) that would be most valuable to supporting the care and needs of this child population and their families and/or caregivers.

Please limit feedback to no more than one page for this item.

Response:

RECOMMENDATIONS INFORMED BY OUR EXPERIENCE IN NEVADA AND NATIONWIDE

SilverSummit commends DHCFP for its approach to providing an integrated benefit set to the SMCP population. This model matches our recommendation and exceeds other State models by including BH, ensuring that one streamlined product can meet this population's specific needs. Our affiliate health plans serve more than 240,000 children in the child welfare system across

21 states, with sole-source contracts in six states. We draw on this nationwide experience and as a current Medicaid plan in Nevada to make the following benefit, population, and programmatic recommendations.

- **Align the SMCP and Medicaid transportation benefit across products.** Aligning the transportation benefits across products will best utilize Nevada's limited resources and mitigate the difficulty of finding a transportation vendor specific to the SMCP population. If the transportation benefit remains fee-for-service in the urban regions for the Medicaid benefit, we recommend it remains fee-for-service for the SMCP benefit.
- **Support families to promote stabilization.** We encourage the State to implement a family care coordination process that allows the SMCP to provide supports, such as transportation or community-based services, for biological parents alongside eligible Members. Supporting entire families will prevent out-of-home placement and encourage reunification.
- **Implement a process for school reintegration.** Often, children returning to school after an extended period away, such as a complex medical or BH need, struggle to reintegrate into the school environment. We recommend that DHCFP work closely with schools and out-of-home placements to implement a process ensuring these children have all the support they need to reenter school and complete their education successfully.
- **Promote continuity of care and minimize disruption by expanding SMCP eligibility.** We recommend allowing children and youth reunified with their parents to remain eligible for the SMCP for 12 months post-reunification, as determined by the parent(s). Our Washington affiliate implemented this option with positive outcomes. We also recommend allowing young adults aged out of foster care to remain eligible until age 26. Lastly, we recommend allowing Members transitioning out of the SMCP and into Medicaid to stay with the same managed care plan, as our Missouri affiliate has implemented.

Implementation Considerations

We are excited to work closely with the State to address potential barriers our affiliates have experienced in identifying, tracking, and outreaching to SMCP populations. ***We recommend carefully and thoughtfully defining eligible populations to ensure nobody falls through the cracks.*** We also recommend implementing a robust data-sharing protocol, inclusive of child welfare agencies, to ensure that the SMCP has all the Member information necessary to provide comprehensive services to each Member.

Value-Added Benefits (VABs)

SilverSummit has witnessed the difference that effective VABs can make in the lives of our Members. We recommend that DHCFP require the SMCP to design and offer a broad range of VABs appropriate for the unique needs of SMCP Members, including preventive care and access to health-related social needs, permanency and reunification, and education and employment supports.

4. PROVIDER NETWORK

The Division seeks feedback on any approaches that it should consider for building, maintaining, and training a high-quality behavioral health workforce serving youth through the development of a new SMCP, including approaches that have been successful in other states. This includes any requirements

for billing support and training through the SMCP, provider reimbursement models or structures, successful utilization management approaches, or value-based payment designs that support the growth and development of the provider infrastructure and reward high performing providers for quality and outcomes.

The Division also seeks specific feedback on the pros and cons of requiring the SMCP to honor Nevada Medicaid's current fee schedule for reimbursement to network providers that deliver critical behavioral health services. In other words, the Division is considering whether it should require the SMCP to pay, at a minimum, no lower than the state's current Medicaid fee schedule to qualified providers for the delivery of behavioral health services to this child population.

Please limit feedback to no more than 1-2 pages for this item.

Response:

RECOMMENDATIONS FOR BUILDING, MAINTAINING, AND TRAINING A HIGH-QUALITY BH WORKFORCE

SilverSummit's Medicaid affiliates provide integrated health care coverage to children and youth through sole-source SMCPs in six states. This national experience, alongside our experience meeting the BH needs of Medicaid Members in Nevada since 2017, informs our recommendations. We support DHCFP's efforts to address service gaps for in-home services, inpatient mental health, peer support, treatment for children and youth with IDD/autism and BH needs, residential treatment, and respite care. We believe that our specific recommendations outlined below to expand access for children with autism and evidence-based treatment will improve access for the SMCP population.

Recommendations to Expand Access for Children with Autism

SilverSummit is committed to reducing access barriers for children with autism and their families. As a current managed care plan in Nevada, we developed outreach and engagement programs to support early identification, educated Providers on the diagnosis and authorization processes, and created family-friendly materials for caregivers. We recognize this is a challenge across the country, not just in Nevada, and we are eager to be a part of the solution. ***We recommend that DHCFP implement an autism diagnosis Provider support model and expand available services to address shortages of Applied Behavioral Analysis (ABA) therapy for children with autism.***

- **Develop an Autism Diagnosis Provider Support Model.** In Nevada, families who suspect their child might have autism begin by visiting a pediatrician. From there, the pediatrician typically refers the family to a psychologist for a formal diagnostic evaluation. This referral pathway creates long wait times before services can begin, even though pediatricians are qualified to diagnose autism. To equip pediatricians with the training and tools necessary to diagnose autism, states such as Missouri, Arizona, and Massachusetts have built regional hubs that centralize expertise, training, and Provider support. Building pediatrician confidence and competence in making autism diagnoses through structured training models like Project ECHO or partnerships with the Nevada Chapter of the American Academy of Pediatrics would reduce unnecessary referrals, expedite care, and enhance early identification.
- **Expand Available Services.** While ABA therapy is an essential and evidence-based intervention for many children with autism, there are additional and complementary treatment options for children who are on a waitlist for ABA. We recommend that DHCFP

consider guidelines that recognize a broader scope of reimbursable autism interventions and promote an individualized, strengths-based approach to care. One such intervention we recommend from our affiliate health plan experience in other states is Developmental Relationship-Based Intervention (DRBI). DRBI is an evidence-informed, person-centered program for children ages 1-18 with diagnosed or suspected autism. DRBI focuses on calm and regulated reciprocal interactions, shared problem solving, and logical and reflective thinking.

Recommendations to Expand Access to Evidence-Based BH Treatment

Based on our experience as the largest managed care company serving children in foster care, we understand that children and youth eligible for the SMCP will need access to evidence-based practices (EBPs) that are effective for those with complex BH needs. Medicaid rates often do not fully cover the cost of EBPs, due to the high cost of implementing and sustaining EBPs to fidelity and effectiveness. ***We recommend that DHCFP explore enhanced reimbursement for EBPs.*** Based on our understanding of what is available in Nevada today, we specifically recommend enhanced reimbursement for Parent-Child Interaction Therapy, Trauma Focused Cognitive Behavioral Therapy, and Youth Screening Brief Intervention and Referral to Treatment. All three of these EBPs have successful outcomes treating children and youth with trauma and complex BH needs.

Many BH Providers who serve children in foster care and with complex BH needs, including EBP Providers, will be new to Medicaid managed care. We know these Providers will need individualized, hands-on support to transition from fee-for-service to managed care successfully. We anticipate these Providers will need to enroll as Nevada Medicaid Providers for the first time and ***encourage DHCFP to create an expedited Medicaid enrollment process for these critical service types to avoid delays in service delivery.***

SilverSummit supports DHCFP's direction to develop requirements for billing support and training through the SMCP, utilization management approaches that increase access to medically necessary care, and value-based payment designs that support the growth and development of the Provider infrastructure and reward high-performing Providers.

FEEDBACK ON REQUIRING SMCP TO HONOR NEVADA MEDICAID FEE SCHEDULE

We support DHCFP's direction to require the SMCP to honor Nevada's Medicaid fee schedule. As a Medicaid managed care plan in Nevada today, most of our Provider contracts are already configured to adjust rates as the fee schedule changes. If the fee schedule increases, our rates systematically increase in kind. Additionally, we recommend that any requirements include flexibility for the SMCP to enter into value-based agreements with Providers.

5. COLLABORATION WITH CHILD WELFARE, COURTS, COUNTIES, SCHOOLS, AND OTHER CHILD-SERVING ENTITIES

The Division seeks feedback and input on any requirements and/or best practices that it should consider for the SMCP to ensure cross-sector collaboration and partnership develops and is maintained in the best interest of the children to be served by the SMCP. It also seeks feedback on ideas for ensuring

transparency with child-serving partner entities with respect to the level of support and collaboration that child-serving entities should expect from the SMCP and options for reporting non-performance. Furthermore, the Division is considering whether it should implement a SMCP coordinating committee that consists of regional representatives from various systems and sectors that serve children in addition to family representatives that would serve as a community advisory committee for the SMCP.

Please limit feedback to no more than 1-2 pages for this item.

Response:

MULTI-SYSTEM COLLABORATION CREATES BEST OUTCOMES

SilverSummit agrees with DHCFP's efforts toward alignment across multiple divisions and systems that serve SMCP-eligible children and their caregivers. We know from experience that the best outcomes for children and families come from a well-coordinated system of care that includes aligned goals, data sharing, and strong communication at all levels of leadership and front-line staff.

Best Practices for Cross-Sector Collaboration

Based on our experience in Nevada since 2017 and our affiliates' experience serving children and youth through sole-source SMCPs in six states, we share the following best practices:

- Establish a Governance Structure that includes the SMCP, the Division, and Child Welfare leaders from Clark County, Washoe County, and DCFS who meet on a regular cadence. We recommend beginning during contract implementation and continue after go-live.
- Develop SMCP reporting requirements through the Governance Structure that can be published publicly on an agreed-upon cadence to provide program transparency
- Include sister agencies that will impact the success of the SMCP, such as Developmental Services and Juvenile Justice
- Develop a communication strategy across system partners, including topics such as benefits, services, and events
- Establish data exchange between all parties, with DHCFP driving requirements and shared standards. This includes encouraging Provider adoption of Nevada's Health Information Exchange.
- Require shared service plans between all Providers and members of a child's care team at initial development and at every update. We recommend that DHCFP make this an SMCP contract requirement and update the Medicaid Service Manual so that Providers have a similar requirement.

Recommendation Regarding the Coordinating Committee

SilverSummit fully supports DHCFP's plan to convene a Coordinating Committee for SMCP stakeholders, including family representatives. We believe that transparent, consistent feedback from the community and those directly impacted by the SMCP will strengthen the program. We recommend that the Coordinating Committee convene quarterly and virtually so that all interested parties can attend regardless of geographic location or access to transportation. We also recommend that DHCFP convene one committee for the entire State and hold breakouts if specific regional issues arise. The following are types of agencies and stakeholders we believe will add value as participants on the Coordinating Committee:

- Individuals with lived experience with the child welfare and/or BH systems
- Child welfare, juvenile justice, and family courts
- Therapeutic Foster Care Agencies
- Behavioral Inpatient and Psychiatric Residential Treatment Facilities
- CMEs responsible for High-Fidelity Wraparound
- Certified Community Behavioral Health Clinics
- Developmental Services within the Aging and Disability Services Division
- Health-related social needs Providers
- Youth shelters
- Housing agencies
- School districts
- Local advocacy groups

6. SOLUTIONS TO MANAGED CARE PITFALLS

Nevada Medicaid recognizes that managed care has strengths and weaknesses, like any delivery system model for risk-based coverage and reimbursement of Medicaid services. Therefore, the Division seeks feedback and input on various mechanisms to address some of the managed care model's weaknesses in the development of a new SMCP for the target child population.

a. Performance: The Division is interested in implementing a public dashboard or tool for tracking the performance of the new SMCP and its network providers. The Division seeks feedback on this idea and the types of quality metrics or indicators that the public and stakeholders would find helpful if the Division implements such a public tool for the SMCP.

b. Profit v. Non-Profit: With respect to a risk-based entity being responsible for serving this vulnerable population, the Division has received some feedback that the type of business entity is important to consider. The Division seeks feedback on whether it should prioritize non-profit over for-profit vendors to serve as the SMCP in the scoring or evaluation process of the procurement. Please explain your answer and the pros and cons of your recommended approach.

c. Vendor Payment*:* The Division is considering a contractual mandate that the SMCP meet a medical loss ratio to ensure most of the funds paid to the SMCP are used to pay for services rendered by network providers instead of vendor overhead and administrative expenses. The Division seeks feedback on the level or percentage of the medical loss ratio that seems appropriate for this population, and if there are recommendations on whether the Division should seek to secure the state's share of the remittances to fund additional bonus payments for the SMCP or providers that are designed to drive greater performance and outcomes.

d. Community Reinvestment: As previously mentioned, the Division is considering some level of community reinvestment for the SMCP with respect to any profits earned by the vendor from operating the managed care program. This would require the SMCP to spend a percentage of its profits annually on certain community-related activities that support this population and do not qualify as covered services or value-added services under the state's contract with the SMCP. The Division seeks feedback on this proposal and the types of activities it should require such investments be spent on by the SMCP pending the level of profits driven by the program.

e. Quality Withhold Payments*:* The Division is considering a withhold arrangement for payment that would allow the Division to "withhold" a portion of the vendor's monthly capitation payment. The amount withheld would become available to the SMCP if it meets certain performance targets or quality

metrics. The Division seeks feedback on this approach and the types of performance or quality metrics it should consider for this withhold payment.

Please limit feedback to no more than 1-2 pages for this item.

Response:

SilverSummit commends DCFP for collecting recommendations to develop the best possible SMCP for Nevada's children and families. We provide feedback for each topic below.

PERFORMANCE

SilverSummit agrees that a public dashboard tracking SMCP and Provider performance will be a positive tool in promoting SMCP accountability through transparency, and we commit to reporting on all metrics required for the dashboard as determined by the State. At a minimum, we recommend that DHCFP include metrics required by the Settlement Agreement driving the creation of the SMCP. These metrics include the number of children in the focus population placed in Residential Treatment Facilities (RTF) on the last day of each month, placed in RTFs out-of-state on the last day of each month, and those hospitalized for a BH need in the previous month.

We recommend that the Governance Structure described in Question Five develop meaningful metrics shared with and finalized through the Coordinating Committee. The Governance Structure should also focus on presenting the data, so it is meaningful and accessible for all potential users. The ongoing dialogue through the Coordinating Committee will allow the dashboard to evolve with the changing needs of the SMCP population.

PROFIT V. NON-PROFIT

SilverSummit believes that the primary focus of the SMCP should be on the well-being of the children and youth in the population. ***Successful experience serving youth in foster care and families at risk of system involvement is a better predictor of future performance than profit or non-profit status.*** Limiting SMCP bidders to those with non-profit status would materially reduce competition and exclude bidders with this meaningful experience.

To that end, ***we recommend that the State's SMCP procurement include a scoring preference for bidders with experience implementing and administering statewide SMCPs for children in foster care without regard to profit or non-profit status***. Profit or non-profit status is not meaningfully linked to better performance serving children and families.

VENDOR PAYMENT

SilverSummit recommends aligning the SMCP medical loss ratio (MLR) with the MLR required by the Medicaid contract. This matches the approach in other states where we manage similar statewide specialty plans. This alignment across contracts enables an easier transition for Members moving to the new SMCP. ***We also support the State funding additional bonus incentive payments, as it will allow DHCFP to direct those funds toward driving better outcomes in the areas of greatest need for the State.***

COMMUNITY REINVESTMENT

SilverSummit agrees that the SMCP should include community reinvestment requirements. We continually exceed the State's community reinvestment requirements through our Nevada Medicaid plan and will continue to do so as the SMCP. ***As an incumbent statewide Medicaid Managed Care plan, SilverSummit already supports children and families that will be covered under the SMCP through our community reinvestment efforts under Medicaid and would build upon these efforts under the SMCP.***

In alignment with Nevada Medicaid, we recommend that DHCFP develop guidelines requiring that the SMCP distribute community reinvestment funds in both rural and urban communities. Similarly, we suggest guidelines requiring that community reinvestment funds be allocated towards the areas of greatest need for this focused population.

QUALITY WITHHOLD PAYMENTS

SilverSummit agrees that a quality withhold arrangement effectively ensures the SMCP consistently meets or exceeds performance and quality measure targets. From experience, however, we anticipate uncertainty around how the SMCP population will access services and difficulty outreaching to certain subsets of the population. These factors may lead to unpredictable outcomes at the outset of the SMCP contract.

For these reasons, ***we recommend that the State collect baseline performance data over the first two years of the contract to inform the development of appropriate measures and benchmarks, with the quality withhold arrangement to begin in the third year of the contract.*** At a minimum, we recommend that DHCFP select measures that align with those in the Medicaid contract, where applicable to the SMCP population. We believe consistent measures across plans and products will reduce Provider administrative burden and drive outcomes that deliver on the State's health care goals for all populations.

HIGH SIERRA AHEC
EDUCATION • HEALTH • COMMUNITY

May 22, 2025

Dear Division of Health Care Financing and Policy,

On behalf of High Sierra AHEC, I am writing to express strong support for the development of a Specialty Managed Care Plan (SMCP) to serve Medicaid-eligible children and youth with behavioral health needs. As an organization dedicated to improving healthcare access and growing a diverse, community-based health workforce, High Sierra AHEC has long supported rural, underserved, and frontier communities through training, career pathway development, and cross-sector partnerships. We appreciate the opportunity to provide comments, particularly in two critical areas: Provider Network Development and Cross-System Collaboration.

Provider Network Development

Nevada's behavioral health provider network urgently needs expansion, particularly in rural and underserved communities where Medicaid-enrolled children and youth face significant service gaps. **BeHERE NV** (https://beherenv.org/about) stands out as a statewide leader in addressing this challenge. Their mission—to expand and diversify Nevada's behavioral health workforce by supporting and encouraging individuals, especially those who are underrepresented, to pursue careers in behavioral health—aligns directly with the goals of the Specialty Managed Care Plan (SMCP).

We recommend the SMCP include the following strategies:

- **Prioritize Statewide Workforce Initiatives Like BeHERE NV:** BeHERE NV is uniquely positioned to lead behavioral health workforce development efforts through its comprehensive strategy that includes outreach, mentorship, scholarships, and connection to employment opportunities. The SMCP should formally partner with BeHERE NV to support pipeline development, student retention, and the transition into practice across Nevada's behavioral health continuum.
- **Integrate Complementary Public Health and Primary Care Pathways:** As a statewide AHEC, High Sierra AHEC plays a key supporting role by offering workforce programs that complement behavioral health career pathways, particularly in community health, primary care, and public health. Our Community Health Worker (CHW) Certification Program and continuing education courses prepare individuals to serve as trusted health connectors, peer supports, and entry-level care coordinators—many of whom work in settings that interface with behavioral health systems. These roles are vital to increasing community-based behavioral health access and capacity.
- **Ensure Equitable and Consistent Reimbursement:** We strongly support requiring the SMCP to reimburse providers at or above the current Medicaid fee schedule. Without fair compensation, it

will be impossible to recruit, train, and retain high-quality behavioral health professionals—especially in rural or underserved areas.
- **Reward Excellence Through Value-Based Design:** The SMCP should explore value-based payment models that reinvest in workforce development and reward quality, culturally competent, and community-centered care.

Cross-System Collaboration

Children and youth with behavioral health needs often navigate multiple systems simultaneously, including education, juvenile justice, child welfare, and healthcare. Coordination failures among these systems result in fragmented care, missed interventions, and long-term consequences for youth and families. We offer the following recommendations:

- **Mandate Local Interagency Collaboration:** Require the SMCP to work closely with Regional Behavioral Health Policy Boards, School Districts, Child Welfare Agencies, and Juvenile Justice stakeholders to develop shared care protocols, real-time communication mechanisms, and wraparound supports.
- **Support School-Based Access Points:** School health programs are often a child's first or only access point to behavioral health services. The SMCP should facilitate co-location of services and provider partnerships within schools—especially in Title I, rural, and frontier schools. Incentives should be provided to encourage behavioral health providers to integrate into school environments and collaborate with Multi-Tiered Systems of Support (MTSS).
- **Fund Workforce Liaisons, Navigators, and Community Health Workers:** Embedding cross-system liaisons, behavioral health navigators, and Community Health Workers (CHWs) in schools, courts, and community organizations will help youth and families access and coordinate care, complete applications, and maintain service continuity. CHWs are uniquely positioned to serve as culturally competent, community-rooted connectors, often bridging gaps in trust, language, and system navigation. These roles should be built into SMCP contracting and reimbursed as integral, billable components of the care team.
- **Include Youth and Family Voice:** Collaboration must also extend to the youth and families themselves. The SMCP should support mechanisms for family input, peer support, and community advisory councils to ensure that services remain person-centered and responsive.

We thank the Division for your leadership and the opportunity to contribute to this vital transformation of our behavioral health system. High Sierra AHEC remains committed to supporting Nevada's children, families, and behavioral health workforce.

May 23, 2025

BACKGROUND:

I have worked with this population of students for thirty years embedded in the Washoe County community, and collaborating with Nevada tribal entities. In this context, I also worked with Nevada DPBH to build out and implement the current Targeted Case Management/Wraparound system, which was facilitated by National Wraparound Implementation Center (NWIC). I also worked to develop the Nevada School-based Health Centers (SBHC) model. I also oversaw a grant to implement Wraparound supports embedded in within a very large youth-serving agency. This grant allowed us to implement the Wraparound model with fidelity. More important, this also opened up access to Wraparound for families and students, outside the foster care system.

Please let me know if I can provide any more information. Please also understand that I am providing this input as a private citizen. This information does not reflect the policies or perspectives of any community agencies.

In this context, please consider the following input:

1. Targeted Case Management:

a locally administered case management service model in a manner that continues to support (if not improve or strengthen) the local administration of these services . . . The goal is to bolster the current system for these services, not supplant them unless the current case management entity prefers that the SMPC take on the case management role.

STRENGTHS:

As our data showed, evidence based targeted case management/Wraparound is a very powerful intervention. The following were some positive results:

- Embedding this intervention in the schools put the resources where the families and students are.
- Embedding this intervention in the schools also took advantage of school-based mental health supports, creating a natural system of care with a care team already connected with the child and family.
- Out of home placements and HSA involvement were reduced.
- Police involvement as a school intervention was reduced.
- For students in foster care, the system of care emphasis created a natural collaborative care team, between school, foster care and HAS, improving outcomes for these students, reducing the need for residential placement and care.

GAPS:

- One end result of the System of Care/Wraparound build out was that access to Wraparound/Targeted Case Management was proscribed, and access was severely limited.

  Related to Medicaid, only Nevada WIN (which I think is overseen by DPBH), can bill Medicaid for wraparound services. So, while community partners were trained to deliver evidence-based Wraparound. Subsequently, only Nevada WIN can bill.

  DPBH oversees Wraparound In Nevada (WIN). WIN provides powerful supports. However, given how small their team is, statistically speaking they have no significant impact on students in the target population in Washoe County.

- Tribal entities can bill for targeted case management, through their Health Centers, under a QMHP. Since this is largely not known by our Tribal partners, this very valuable intervention is not utilized at this level.

- **Please note** that there currently is no "locally administered case management" of Wraparound/Targeted Case Management that provides or oversees the "the local administration of these services " in Washoe County.

- **Please note** – there is one community non-profit agency in Washoe County that says they provide "Wraparound/Targeted Case Management. They don't.

- Both State entities that provide grant funding for Wraparound/targeted case management, and WCSD, do not build to ensure sustainability.

  A valuable Project AWARE grant provided by the State to WCSD had a wraparound/targeted case management component. This will not be sustained, in part, because of lack of vision for sustainability within WCSD.

RECOMMENDATIONS:,

- Clark County School District (CCSD) has been implementing a Wraparound Division, for at least ten years.

  This seems to reflect a commitment by CCSD to provide some level of funding for this intervention, making it accessible to all students and families.

  The Medicaid team may want to collaborate with CCSD and build out on their model to make this services more widely accessible.

- Currently, Medicaid billing is only allowed for the very small (very good) WIN team in Washoe County. Given the size of the team, there is no way this service can be provided to meet the needs of a highly impacted community of over 61,000 children and youth.

  Consider expanding Medicaid billing capacity to school districts. This would provide motivation for school districts to train school staff, and open up access to their students and families.

- **Please ensure that approved Wraparound/Targeted Case Management is an evidence-based practice, research-based practice.**

  If this isn't defined and specified, vendors or community nonprofit agencies can bill for practices that are sloppy or nonexistent, at best. This would waste Medicaid funds. More importantly, it would not address the needs of the students and their families in the target population.

- **Please understand that the failure noted by US DOJ, is not just a State failure, but a failure of "localities" to prioritize the needs of this population. Therefore, trusting localities to decide if they need help and oversight, may not be a good idea, at the outset.**

2. CARE MANAGEMENT APPROACH:

Requiring the SMCP to provide the care management services whether that be through the SMCP entity itself, or through a subcontract with another entity for statewide services or a number of other entities . . .regionally.

Please limit feedback to no more than one page for this item

THOUGHTS:

- Current outcomes seem to suggest that one state-run entity overseeing a Case Management Approach has been ineffective in expanding Case Management to benefit families most in need.

  It may be important to do some kind of evaluation of existing processes, to identify what has caused these gaps.

- The NWIC model is complex, and depends to highly trained (QMHP-level) practionners.

  There are other models that may be more user friendly, including the Milwaukee Model. This model was implemented with very good effect, by the State of Nevada for many years, before the State stepped in and complicated things.

- **In terms of selecting "vendors," please remember that vendors are businesses are trying to make money out of "health care" right now. Using this option would open the State and our people up to vendors who are very good at sales, and have little/no impact.**

  As noted above, there is currently a community-based entity in Washoe County that says they are providing "wraparound." WCSD also cites "wraparound" as one of our interventions.

- In terms of, regionalized CMEs – If they were overseen by the State, the way NNCAS, PRTF, and Regional Centers are, this would protect youth and families from vendors/agencies who promise services, collect money, and do not deliver the supports.

- This more regionalized model, may be more effective in overseeing this highly valuable intervention, particularly because regionalized "hubs" are more embedded in their communities and more committed to outcomes for their children and families.

- The State School-based Health Center model, has continued to be implemented in CCSD, and also in some of our rural communities, including Lyon County and Carson City.

3. **Benefit Set:** Currently, the Division is working to implement the SMCP delivery system using a best practice model that provides for an integrated benefit set of medical care, including basic and hospital services, pharmacy and transportation, among others, and behavioral health services into one coverage product or plan for the child. The goal is to ensure that the "wholechild" approach to care is achievable and to remove any unintended silos in current systems where home or community-based services are managed separately from the medical benefits in Medicaid.

A "whole-child" approach is best practice.

- Nevada Medicaid Services Manual, ch. 2800 provides a good working model for a "whole-child approach", including evaluation by qualified, licensed professionals, leading to a "plan of care (POC)," which creates a collaborative, community-braided system of support for the child or youth.
- Evidence-based Wraparound, supports by our Human Services Agencies, and now, practices at Washoe Juvenile Services also are working to working toward this integrated approach.
- The larger system of care is fragmented, and silo'ed.

  Agencies providing essential services, including mental health and behavioral services are reluctant to support Medicaid youth because of how clumsy the billing process is, because Medicaid may delay payments, and because providers have been directed to repay large amounts of money to Medicaid.

  As mentioned earlier, some vendors have shifted to a "money making" approach rather than a community services approach.

  Some vendors soak of State funding for essential services, say they are delivering services like wraparound, and not providing these services.

  Agencies like WCSD, do no prioritize this population of highly vulnerable youth, depending on arrest and incarceration as interventions.

  Our rural communities do not have access to the whole array of services these youth need.

4. **Provider Network:** Nevada's behavioral health care continuum requires expansion and ongoing development. Many behavioral health providers do not participate in the Medicaid program and there are significant service gaps, including for in-home services, inpatient mental health, peer support, treatment for children and youth with IDD/autism and behavioral health needs, residential treatment (leading to out-of-state placements), and respite care. The state is also heavily impacted by the national crises of youth behavioral health needs and behavioral health workforce shortages.

a. In terms of "service gaps" –

- Private agencies, including residential treatment partners in Northern Nevada, refuse to take students who have IDD/autism, or students who have aggression related to PTSD or mental health issues.

  So these vendors benefit from Medicaid funding for the youth they want to serve, and refuse to support the youth who are the population of concern for the US DOJ investigation.

- Behavior analytic partners in the North also refuse to take youth with underlying aggression.

  I suppose the State cannot mandate that private vendors serve students who are aggressive. Also, liability insurance often will not cover staff members who are injured at work. This is another gap.

b. . . . any approaches that it should consider for building, maintaining, and training a high-quality behavioral health workforce serving youth through the development of a new SMCP. . .

- One great strength of State DOE, DPBH, DCS is that they are constantly working hard to make grant funding available to communities.

  Unfortunately, since there is no sustainability plan or mandate, projects that could build out our system of care, fade and disappear once the grant funding runs out. This includes System of Care grants, Wraparound grants, Project AWARE.

  When the grant funding disappears, the supports disappear.

- The US DOJ findings reflect a very real failure of the Nevada System of Care. Some of the responsibilities does fall on the largest child/family serving agencies – school districts – to comply with Federal and State law – particularly Federal Individuals with Disabilities Education Act (IDEA) – which mandates adequate supports and services for the target population.

RECOMMENDATIONS --

Results of the US DOJ investigation indicate a failure by communities, and by the State to provide an effective, "whole child," child centered system of support for this population of youth.

If the State were to investigate school districts, in terms of their arrest and incarceration rates for these youth, they would find that school districts struggle to meet these students' needs and depend on incarceration.

- For WCSD, this is a failure to prioritize the needs of these students. It's easier to arrest than to support.

  It may be important for an SMHP to have a compliance function, that ensures agencies, including school districts, comply with Federal and State law, to ensure the success of these students. Arrest and incarceration resulting from lack of adequate supports in school actually indicate violations of Federal IDEA and NAC.

- For our rural partners, they do not have access to necessary supports and services.

- It would also be interesting to collect data on how many students with autism, in foster care, and with underlying significant mental health concerns, have been held at juvenile detention centers because there is no other place for them.

c. The Division also seeks specific feedback on the pros and cons of requiring the SMCP to honor Nevada Medicaid's current fee schedule for reimbursement to network providers that deliver critical behavioral health services.

- In conversations with private vendor partners, they have no concern with following reimbursement schedules for students who receive Fee For Service Medicaid.

- Other Medicaid insurers make reimbursement for essential services almost impossible. So, providers will refuse to take these forms of Medicaid.

5. **Collaboration with Child Welfare, Courts, Counties, Schools, and Other Child-Serving Entities:** Nevada Medicaid seeks to align efforts across multiple divisions and systems responsible for children and youth who are in foster care or have behavioral health needs. Shared systems, technologies, and processes are needed for children served by multiple state and local agencies, including child welfare, court systems, juvenile justice, and/or school systems, among others

a. I was involved in and observed the initial impetus for the US DOJ investigation and findings. As indicated above, failures included the following:

- Lack of appropriate services and supports for these youth including:

  ✓ Adequate, timely mental health care – psychiatric and psychotherapeutic
  .
  Medicaid only allows for 50 minutes "med checks" with any youth. This highly restricts the ability of our most skilled providers to provide quality care.
  A shift to telehealth, also means that psychiatrists and APRNs may quickly process youth, and not provide quality care.

  ✓ Lack of community agency/vendors how are willing to work with this population of students.

- Community providers often are not reimbursed for cross-agency partner collaboration for youth.

  This defeats the point of Wraparound, since community partners may not be able to engage.

  Reimbursement for ABA does provide a good model, because Medicaid will reimburse behavior analysts for about an hour a week to collaborate with school teams.

b. "The Division seeks feedback and input on any requirements and/or best practices that it should consider for the SMCP to ensure cross-sector collaboration and partnership develops and is maintained in the best interest of the children to be served by the SMCP."

The State or SMCP may need to mandate cross-sector collaboration and partnership for any agency receiving State funding.

Right now, based on observation, cross-sector collaboration is more optional than required. This, alone, to ensure fragmentation of services and failure for this population of youth.

6. **Solutions to Managed Care Pitfalls:** Nevada Medicaid recognizes that managed care has its strengths and weaknesses, like any delivery system model for risk-based coverage and reimbursement of Medicaid services. Therefore, the Division seeks feedback and input on various mechanisms to address some of the weaknesses of the managed care model in the development of a new SMCP for the target child population.

a. Performance: The Division is interested in implementing a public dashboard or tool for tracking the performance of the new SMCP and its network providers. . . and quality metrics or indicators

- Arrest
- Incarceration
- School attendance
- School behavior data – emergency suspensions and threat assessments. Both of these are flags for distress of the youth and family

  Right now the State mandates that emergency suspension data are collected by school districts yearly, and posted on the school district website.

  The last time CCSD did this was 2023.
  WCSD has never done this.

School districts are uniquely positioned to identify students with/suspected of SED, and to provide early intervention.

School districts are uniquely positioned to ensure protection for students, and to flag abuse and neglect.

If the State does not respond to data, in terms of ensuring compliance, outcomes for this population will never change.

b. Profit v. Non-Profit: With respect to a risk-based entity being responsible for serving this vulnerable population, the Division has received some feedback that the type of business entity is important to consider. The Division seeks feedback on whether it should prioritize non-profit over for-profit vendors to serve as the SMCP in the scoring or evaluation process of the procurement. Please explain your answer and the pros and cons of your recommended approach.

As mentioned throughout, I have observed that both for profit and non-profit partners see projects like this as "money making ventures." As such, they often take the money and run.

Millions of dollars were given to Clark County to build out a mental health serving center. The provider took the money, and left within a year.

Vendors have also taken money for Community Mental Health Centers, run the center until the money ran out, then closed the center.

The State may want to reconsider using their own existing agencies – ie. NNCAS, PRTF, SRC – as agents or overseers of the SMCP, to minimize this exploitation of State funds.

About 20 years ago, the State tested the hypothesis that they could either close down or greatly shrink the supports at NNCAS. This is still a very good agency, with good services. And, outcomes speak for themselves, in terms of the community's ability and commitment to care for these youth.

c. Community Reinvestment: As previously mentioned, the Division is considering some level of community reinvestment for the SMCP with respect to any profits earned by the vendor from operating the managed care program.

Again, this flags my cynicism of using money-making vendors to oversee this system.

The recent failure of the Washoe Crisis Care Center is a good example. This Center stayed open for about a month before closing.

The vendor is a good partner, with vision for supporting the community. However, they are an example of a community partner that did not have a plan for sustainability, much less reinvestment in the community.

Originally, this Crisis Care Center was funded by the State. Three years ago, this Crisis Care Center was supposed to open for adolescents and pediatrics, with a unit for students with neurodevelopmental needs. This shifted to adult care, for some reason.

As you can see based on US DOJ findings, the most pressing need for this support is for the target population of students with/suspected of SED, and IDD/austim impacted youth.

Summary of RFI Feedback: Specialty Managed Care Plan for Children and Youth with Behavioral Health Needs

Nevada Medicaid | July 2025

Background

In response to a Department of Justice (DOJ) Settlement Agreement and Nevada's commitment to improving behavioral health outcomes for children and youth, Nevada Medicaid issued a Request for Information (RFI) in April–May 2025 to gather public input on the design and implementation of a new Specialty Managed Care Plan (SMCP).

The RFI sought feedback across six structured categories:

1. Targeted Case Management
2. Care Management Approach
3. Benefit Set
4. Provider Network
5. Cross-System Collaboration
6. Solutions to Managed Care Pitfalls

Submissions Received

A total of 26 RFI responses were received, including submissions with and without attachments. Feedback came from a diverse set of stakeholders:

- Managed Care Organizations (MCOs): 6
- Hospitals / Health Systems / Academic Institutions: 3
- County Agencies: 2
- Advocacy and Nonprofit Organizations: 5
- Family/Youth with Lived Experience: 4
- Vendors / Tech Partners: 3
- State Agency Staff: 2

Key Themes Across Categories

- **Targeted Case Management (TCM)**
- Broad support for a hybrid or regionalized model, with local Care Management Entities (CMEs) delivering case management under SMCP oversight.
- Counties, especially Clark County, emphasized preserving local control, requesting an opt-out option to prevent service duplication.
- High-Fidelity Wraparound was universally recommended as the core model for TCM.
- 2. Care Management Approach

- Stakeholders endorsed a tiered care coordination framework, often supported by use of the Child and Adolescent Needs and Strengths (CANS) tool.
- Strong emphasis on integrating certified youth and family peer support specialists into care teams.
- CMEs were identified as essential partners in community-based, culturally responsive service delivery.
- 3. Benefit Set
- Widespread agreement that SMCP should offer an integrated, "whole-child" benefit package, including:
- Behavioral health, physical health, pharmacy, and HCBS
- Respite care, mobile crisis, and family stabilization supports
- Value-added benefits such as caregiver navigation, transportation, technology access, and transition-aged youth services
- Some stakeholders, such as Foster Kinship and NAMI, emphasized the need to extend coverage to informal caregivers and youth after reunification.
- 4. Provider Network
- Universal recognition of a behavioral health workforce crisis, with consensus around:
- Need for enhanced reimbursement (some recommending doubling fee schedules)
- Investments in training, clinical supervision, and loan repayment programs
- Simplified billing and prior authorization processes to reduce administrative burden
- 5. Cross-System Collaboration
- Respondents supported formal coordination mechanisms, including:
- MOUs between the SMCP and state/local agencies
- A statewide SMCP Coordinating Committee and regional advisory groups
- Real-time care planning and communication platforms to improve coordination with courts, schools, and child welfare
- Emphasis was placed on transparency, shared decision-making, and incorporation of family voice.

- **Solutions to Managed Care Pitfalls**
  - Strong support for a public performance dashboard with metrics aligned to the DOJ Settlement (e.g., psychiatric hospitalizations, residential placements, wait times).
  - Most supported a Medical Loss Ratio (MLR) minimum of 85–90%, with remittance or reinvestment requirements.
  - Stakeholders endorsed 3–5% quality withhold payments, phased in over time and tied to meaningful performance outcomes.
  - Entity type (nonprofit vs. for-profit) generated some divergence: while advocacy groups prefer nonprofits, most emphasized performance and reinvestment capacity.

Stakeholder	Common Priorities

MCOs	Phased implementation, integrated benefits, value-based payment alignment
Counties	Maintain case management control, reduce duplication, align with local systems
Nonprofits / Advocates	Peer/family support, informal kin coverage, accountability from day one
Health Systems	Clear eligibility criteria, rate reform, professional infrastructure
Family/Lived Experience	Crisis avoidance, navigation, trauma-informed access and continuity

The RFI revealed strong alignment around core design elements such as hybrid delivery models, wraparound care, and reinvestment in workforce and infrastructure. Differences emerged around implementation pace and the degree of SMCP centralization. Stakeholders emphasized the importance of co-designing the SMCP with local input, ensuring transparency, and holding plans accountable to quality outcomes and community priorities. This feedback will inform procurement design, SMCP contract development, and policy decisions over the coming year.

Emerging Themes

1. Targeted Case Management (TCM):

- **Hybrid/Regional Model Consensus**:
  Most stakeholders supported a hybrid or regionalized TCM model. Entities such as CareSource, SilverSummit, and Renown/UNR Med advocated for contracts with regional Care Management Entities (CMEs), allowing for local implementation with SMCP oversight.
- **County Perspective**:
  Clark County opposed duplicative SMCP-led case management and emphasized preserving county control, with flexibility to opt out of centralized models.
- **High-Fidelity Wraparound**:
  Wraparound was consistently named as the preferred framework for TCM.

2. Care Management Approach:

- **Care Coordination**:
  Strong support across submissions for a coordinated, trauma-informed approach, often citing the CANS assessment as a tool to support tiered care coordination.
- **Peer Support Integration**:
  CareSource, NAMI Nevada, and others emphasized the value of certified youth and family peer support roles in care teams.
- **CME Role**:
  CMEs were recommended as essential to embedding care within communities and ensuring cultural and geographic relevance.

3. Benefit Set:

- **Whole-Child Model**:
  Entities like SilverSummit, Renown/UNR Med, and FirstMed endorsed an integrated benefit package that includes primary care, behavioral health, and home/community-based services.
- **Value-Added Services**:
  Common recommendations included:
- Respite care (emergency and planned)
- Mobile crisis services
- Support for family reunification
- Post-reunification eligibility for youth
- Transportation and telehealth
- **Special Populations**:
  Informal kinship caregivers, transition-age youth, and youth with co-occurring IDD and SED/SMI were repeatedly mentioned as needing tailored benefits.

4. Provider Network:

- Workforce Development Priorities:

- Enhanced reimbursement (doubling Medicaid fee schedule was suggested)
- Incentives for EBP adoption
- Support for supervision, training pipelines, and CHW certification
- **Administrative Simplification**:
  Delays from prior authorizations and billing burdens were identified as barriers to network growth.

5. Cross-Sector Collaboration:

- **Integrated Partnerships**:
  Most responses urged strong interagency collaboration between SMCP, counties, courts, schools, and other child-serving systems.
- Formal Structures Proposed:

- MOUs or data-sharing agreements
- A statewide Coordinating Committee
- Regional advisory groups
- **Technology Solutions**:
  Tools to enable real-time coordination and shared care plans were endorsed by several tech-enabled vendors and systems partners.

6. Solutions To Managed Care Pitfalls:

- **Public Dashboards**:
  Broad support for public-facing performance dashboards with metrics like:
- Hospitalization and residential placement
- Time to service initiation
- Peer support engagement
- **Medical Loss Ratio (MLR)**:
  Most recommended a minimum MLR of 85-90%, with remittance or reinvestment into community programs.
- **Quality Withhold Payments**:
  Most supported a phased 3-5% withhold structure linked to meaningful performance measures.
- **Profit vs. Nonprofit**:
  While some preferred nonprofit contractors, others emphasized capacity, experience, and mission alignment over tax status.
- **Community Reinvestment**:
  Respondents strongly supported reinvesting plan profits into local services, especially for rural and underserved areas.

Cross-Cutting Recommendations

- Use of the CANS Tool for clinical decision-making and eligibility determination.
- High-Fidelity Wraparound and CME models as structural foundations.
- Family and Youth Voice embedded in care teams and planning structures.
- Inclusion of non-traditional service settings, such as schools, foster care settings, and community hubs.

Comparisons Across Stakeholders

MCOs: Integration, incentives, medical loss ratio, managed care infrastructure

Counties: Maintaining local control and avoiding service duplication

Nonprofits/Advocacy: Peer support, lived experience, access for underserved communities

Health Systems: Rates, workforce strain, clinical eligibility standards

Family/Youth Voices: Navigation, trauma-informed systems, flexible and timely access to services

Key Takeaways

- Consensus exists around regionalized care models, especially CMEs and wraparound frameworks.
- Stakeholders emphasized elevating peer support and family voice as core elements of system design.
- System navigation, reimbursement adequacy, and workforce development are pivotal to successful implementation.
- Data transparency, local reinvestment, and interagency collaboration are widely regarded as non-negotiable. A phased implementation with clear metrics and incentives is preferred to ensure success without disruption.

Emerging Themes by RFI Category

Key Takeaways:

- Consensus exists around regionalized care models, especially CMEs and wraparound frameworks.
- Stakeholders emphasized elevating peer support and family voice as core elements of system design.
- System navigation, reimbursement adequacy, and workforce development are pivotal to successful implementation.
- Data transparency, local reinvestment, and interagency collaboration are widely regarded as non-negotiable.
- A phased implementation with clear metrics and incentives is preferred to ensure success without disruption.

1. Targeted Case Management (TCM)

Emerging Themes:

- Hybrid/Regional Model Consensus: Most stakeholders supported a hybrid or regionalized TCM model. Entities such as CareSource, SilverSummit, and Renown/UNR Med advocated for contracts with regional Care Management Entities (CMEs), allowing for local implementation with SMCP oversight.
- County Perspective: Clark County opposed duplicative SMCP-led case management and emphasized preserving county control, with flexibility to opt out of centralized models.
- High-Fidelity Wraparound: Wraparound was consistently named as the preferred framework for TCM.

2. Care Management Approach

Emerging Themes:

- Care Coordination: Strong support across submissions for a coordinated, trauma-informed approach, often citing the CANS assessment as a tool to support tiered care coordination.
- Peer Support Integration: CareSource, NAMI Nevada, and others emphasized the value of certified youth and family peer support roles in care teams.
- CME Role: CMEs were recommended as essential to embedding care within communities and ensuring cultural and geographic relevance.

3. Benefit Set

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- Value-Added Services: Common recommendations included:
    - Respite care (emergency and planned)
    - Mobile crisis services
    - Support for family reunification

    - Post-reunification eligibility for youth
    - Transportation and telehealth
- Special Populations: Informal kinship caregivers, transition-age youth, and youth with co-occurring IDD and SED/SMI were repeatedly mentioned as needing tailored benefits.

4. Provider Network

Emerging Themes:

- Workforce Development Priorities: Stakeholders emphasized urgent need for:
    - Enhanced reimbursement (doubling Medicaid fee schedule was suggested)
    - Incentives for EBP adoption
    - Support for supervision, training pipelines, and CHW certification
- Administrative Simplification: Delays from prior authorizations and billing burdens were identified as barriers to network growth.

5. Cross-Sector Collaboration

Emerging Themes:

- Integrated Partnerships: most responses urged strong interagency collaboration between SMCP, counties, courts, schools, and other child-serving systems.
- Formal Structures Proposed:
    - MOUs or data-sharing agreements
    - A statewide Coordinating Committee
    - Regional advisory groups
    - Technology Solutions: Tools to enable real-time coordination and shared care plans were endorsed by several tech-enabled vendors and systems partners.

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Emerging Themes:

- Public Dashboards: Broad support for public-facing performance dashboards with metrics like:
    - Hospitalization and residential placement
    - Time to service initiation
    - Peer support engagement
- Medical Loss Ratio (MLR): Most recommended a minimum MLR of 85-90%, with remittance or reinvestment into community programs.
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- Profit vs. Nonprofit: While some preferred nonprofit contractors, others emphasized capacity, experience, and mission alignment over tax status.
- Community Reinvestment: Respondents strongly supported reinvesting plan profits into local services, especially for rural and underserved areas.

Cross-Cutting Recommendations:

- Use of the CANS Tool for clinical decision-making and eligibility determination.
- High-Fidelity Wraparound and CME models as structural foundations.

- Family and Youth Voice embedded in care teams and planning structures.
- Inclusion of non-traditional service settings, such as schools, foster care settings, and community hubs.

Comparisons Across Stakeholders

Stakeholder	Unique Emphasis
MCOs	Integration, incentives, medical loss ratio, managed care infrastructure
Counties	Maintaining local control and avoiding service duplication
Nonprofits/Advocacy	Peer support, lived experience, access for underserved communities
Health Systems	Rates, workforce strain, clinical eligibility standards
Family/Youth Voices	Navigation, trauma-informed systems, flexible and timely access to services

Overview of RFI Feedback Submissions

Nevada's Specialty Managed Care Plan (SMCP)

Overview: Between April and May 2025, Nevada Medicaid solicited public input through a formal Request for Information (RFI) to inform the design of a new Specialty Managed Care Plan (SMCP) for children and youth with behavioral health needs. The RFI invited structured feedback across six categories: Targeted Case Management, Care Management Approach, Benefit Set, Provider Network, Cross-System Collaboration, and Managed Care Safeguards.

Total Submissions Received:

- 26 total submissions
- Responses included both email-only comments and formal letters with attachments.

Entities Represented:

- 6 Managed Care Organizations (MCOs):
- CareSource, SilverSummit, Anthem, UnitedHealthcare, Molina, Magellan
- 3 Health Systems / Academic Medical Centers:
- Renown/UNR Med, Intermountain Children's Health, FirstMed (FQHC)
- 2 County Entities:
- Clark County Department of Family Services and Juvenile Justice Services
- 5 Nonprofit / Advocacy Organizations:
- NAMI Nevada, Foster Kinship, High Sierra AHEC, Legal Aid Center of Southern Nevada, Mental Health America of Nevada
- 4 Family/Youth or Lived Experience Respondents:
- Individual caregivers and advocates with firsthand system navigation experience
- 3 Tech and Policy Vendors:
- Connect Our Kids, YourCasePlan, Eagle Quest (FFTA)
- 2 State Staff / Government Employees:
- Comments submitted by Division of Child and Family Services staff

Feedback Themes:

- Support for a hybrid/regional Care Management Entity (CME) model with SMCP oversight
- Emphasis on peer support, family voice, and culturally responsive care
- Broad agreement on the need for an integrated benefit set, including respite, mobile crisis, and transition supports
- Strong consensus that provider reimbursement rates are insufficient and workforce investments are critical
- Calls for shared governance, public performance dashboards, and meaningful cross-system accountability
- Recommendations to prioritize reinvestment into local infrastructure and workforce, particularly in rural areas

Areas of Alignment (Consensus):

Hybrid or Regionalized Service Delivery

- Broad agreement that a regional model using Care Management Entities (CMEs) or locally led wraparound teams is the best structure for delivering TCM and care coordination.
- Stakeholders agreed that this approach balances local expertise with state or SMCP oversight.

High-Fidelity Wraparound as the Preferred Framework

- Nearly all entities endorsed wraparound care as the foundational approach for both targeted case management and intensive care coordination for youth with complex needs.

Integrated, Whole-Child Benefit Set

- Respondents supported a fully integrated plan that includes:
- Medical, behavioral health, and pharmacy
- HCBS and school-based services
- Value-added benefits such as respite, transportation, and telehealth

Urgent Need for Provider Network Investment

- Agreement that Medicaid rates are too low.
- Support for:
- Enhanced reimbursement for EBPs
- Loan repayment and training pipelines
- Reduced administrative burden (e.g., prior authorization)

Inclusion of Peer Support and Family Voice

- Multiple entities emphasized certified youth and family peer support roles.
- Support for building peer-run services and integrating peer specialists in care teams.

Need for Transparency and Accountability

- Strong support for a public dashboard and cross-sector performance tracking.
- Agreement that quality withhold payments and MLR minimums should be used to drive plan performance.

Cross-System Collaboration

- Formal agreements (MOUs, shared protocols)
- Regional and statewide advisory structures
- Shared care planning and communication platforms

Areas of Divergence:

Role of SMCP vs. Counties in Case Management

- Counties (e.g., Clark County):
  - Want to retain primary case management roles.
  - Oppose duplicative TCM functions by the SMCP.
  - Request an opt-out or carve-out for county-led systems.
- MCOs and Providers:
  - Support the SMCP contracting with CMEs and overseeing case management functions statewide.
  - View SMCP oversight as necessary for accountability and standardization.

For-Profit vs. Nonprofit Plan Preferences

- Legal Aid Center, NAMI, and some advocacy groups: Prefer nonprofits, citing stronger community ties and mission alignment.
- MCOs (Magellan, UnitedHealthcare): Emphasize performance, community reinvestment, and regulatory oversight as more important than tax status.

Specific Definitions and Eligibility Criteria

- Some providers (e.g., Renown/UNR Med) call for clearly defined eligibility criteria for "high-risk" populations and SED/SMI determinations.
- Others did not emphasize standardization but focused more on broad access.

Implementation Pace and Quality Incentives

- MCOs like SilverSummit and UnitedHealthcare: Recommend phased implementation of quality withhold payments and dashboards.
- Advocacy groups: Want performance tracking and incentives built into the system from the beginning to ensure accountability.

Summary Comparison Table:

	Areas of Agreement	Areas of Divergence
Targeted Case Management	Regional model using CMEs; Wraparound care preferred	Counties want local control and flexibility to opt out
Benefit Set	Whole-child design, including HCBS and VABs	Some variation in detail (e.g., scope of transition supports, school-based supports)
Peer Support	Strong support for peer specialists in care teams	Differences in how peer support is reimbursed or integrated
Provider Network	Need for higher rates, training pipelines, EBP reimbursement	No major divergence

Public Accountability	Support for dashboards, quality withholds, MLR reinvestment	Timing and performance thresholds debated
SMCP Entity Type	Desire for strong performance and reinvestment	Split between prioritizing nonprofit vs. allowing high-performing for-profits
Cross-Sector Coordination	Broad support for shared care planning and advisory committees	Different expectations for platform design or agency control

APPENDIX

1. TARGETED CASE MANAGEMENT (TCM)

- Hybrid/Regional Model Consensus

County Perspective

High-Fidelity Wraparound

2. CARE MANAGEMENT APPROACH

- Care Coordination

Peer Support Integration

CME Role

3. BENEFIT SET

- Whole-Child Model

Value-Added Services

Special Populations

4. PROVIDER NETWORK

- Workforce Development Priorities

Administrative Simplification

5. CROSS-SECTOR COLLABORATION

- Integrated Partnerships

Formal Structures Proposed

Technology Solutions

6. SOLUTIONS TO MANAGED CARE PITFALLS

- Public Dashboards

Medical Loss Ratio (MLR)

Quality Withhold Payments

Profit vs. Nonprofit

Community Reinvestment

MCOs

Counties

Nonprofits/Advocacy:

Health Systems:

Family/Youth Voices:

1. Hybrid or Regionalized Service Delivery
2. High-Fidelity Wraparound as the Preferred Framework
3. Integrated, Whole-Child Benefit Set
4. Urgent Need for Provider Network Investment
5. Inclusion of Peer Support and Family Voice
6. Need for Transparency and Accountability
7. Cross-System Collaboration

1. Role of SMCP vs. Counties in Case Management
2. For-Profit vs. Nonprofit Plan Preferences
3. Specific Definitions and Eligibility Criteria
4. Implementation Pace and Quality Incentives

May 22, 2025

Submitted via email: ChildrensBH@dhcfp.nv.gov

RE: "Implementation of a New Specialty Managed Care Plan for Certain Children and Youth Populations"

To Whom It May Concern –

Targeted Case Management

The Division is seeking feedback on this model and any best practices or lessons learned from similar approaches to integrating a Specialty Managed Care Plan (SMCP) (or managed care model) into a locally administered case management service model in a manner that continues to support (if not improve or strengthen) the local administration of these services if that is a desired outcome by the locality. The goal is to bolster the current system for these services, not supplant them unless the current case management entity prefers that the SMCP take on the case management role.

Response: We value an approach that bolsters the current system and retains the expertise of the current targeted case management (TCM) providers, particularly during a transitional period when the Division is establishing this new specialty managed care system. Based on our experience coordinating with community and county-based providers of targeted case management in other states, we believe there are some best practices the Division should consider when integrating the new SMCP into this hybrid model.

- Develop clear data integration requirements so that there is the ability for the SMCP to engage in needed quality management activities and provide data on the effectiveness of the services rendered by the TCM providers.
- Establish a formal process for reviewing members receiving case management services between SMCP and TCM providers to support an aligned approach to member care, promote collaboration, and reduce member abrasion.
- Require a standard quality oversight process for all TCM services to ensure consistency and fidelity to services given the geographic variation across the state and difference in access and delivery system availability between urban, suburban, rural, and frontier communities.

Care Management Approach

The Division seeks information on recommended best practices for care management and feedback on the best approach to ensuring quality care management services are available statewide for this child population with the implementation of a new SMCP.

Response: To effectively serve the needs of children and youth with behavioral health needs including those involved with the foster care system, a care management approach must be coordinated, individualized, provided by individuals trained in trauma-informed care, and available in formats or settings aligned with the needs of the child, youth, and family. We encourage the Division to establish the SMCP as the single point of accountability in order to ensure this approach is taken.

Providing the SMCP with the responsibility as primary care management lead ensures they are able to act as a hub for the child's holistic plan of care, reduces the complexity for children and youth with specialized health care needs and those supporting them, and allows for successful delivery of services and supports that can meet their unique needs. We encourage the Division to require the SMCP care managers and related multidisciplinary care team members to be specially trained to serve the complex and unique needs of this population. Specifically, the SMCP should be required to develop care teams that specialize in addressing family support needs, behavioral health, and medication support, as well as person-centered transitional services for children and youth as they transition to adulthood.

The SMCP's approach to care management should be informed by comprehensive assessments and screenings. In addition, the SMCP should utilize a system of care approach to care management and leverage collaborations with child welfare, juvenile justice, community-based organizations, schools, providers inclusive of behavioral health, and families. By doing so, the SMCP is ensuring these systems are wrapping around the child and their family to decrease barriers to access ensuring they are receiving needed supports and services.

To the greatest extent possible, care should be community-based and provided via modalities that meet the engagement preferences and capabilities of the population and allow for collaborative care planning and coordination across all engaged stakeholders. We encourage the Division to support the SMCP in making available devices and providing technical support/education to children, youth, families, and providers to support these digital/virtual engagements. This approach and support will help ensure quality care management services are available across the state in urban, rural, and frontier areas.

Benefit Set

The Division seeks feedback on this approach and any best practices or lessons learned about implementing an integrated benefit set for this population. The Division also seeks input on the types of value-added benefits (outside of the Medicaid-covered benefits) that would be most valuable to supporting the care and needs of this child population and their families and/or caregivers.

Response: A comprehensive and integrated array of benefits—physical, behavioral, pharmacy, and social drivers of health/home and community-based services (as needed)—and a coordinated systems approach is required to ensure successful health care delivery that meets the unique needs of this population. In addition to physical and behavioral health integration in benefit design, service delivery, and administrative structure, comprehensive dental and vision benefits should be integrated. Oral health is linked to overall physical health outcomes and emotional well-being.

We appreciate the Division's efforts to authorize new services including family and peer supports, respite care, and wraparound coordination in the envisioned benefit design for the SMCP. Additional services should be considered to address the covered population's complex needs including helping to address the trauma particularly that children and youth in foster care have been exposed to. Services such as partial hospitalization and alternatives to residential care or other out-of-home placements, such as Multisystemic Therapy (MST), can be tailored to address the unique needs of

the population and support the provision of care in the least restrictive setting possible. Other evidence-based services (consistent with Families First) like Trauma-Focused Cognitive Behavioral Therapy, Parent Child Interaction Therapy (PCIT), Exposure and Response Prevention Therapy (ERPT), and Child-Parent Psychotherapy (CPP) should also be considered and have designated billing modifiers and rates to encourage provider use and appropriate compensation for trauma-informed care modalities. Additional sensory and expressive therapies that have shown to be effective for some children and youth as well as substance use treatment services especially for pregnant individuals in foster care should also be considered in developing the dedicated benefit package for this population. In all cases, any covered benefits should be adequately funded and incorporated into the health plan capitation rate.

We agree that value-added benefits (VABs) are a critical component to improving quality and ensuring positive health outcomes. These benefits should be tailored to the needs of the population, and in addition, should be specifically targeted as diversions from PRTFs. VABs should also be considered through the lens of the family unit and what would benefit not only the child but also their family supports and caregivers. As a result, we suggest considering the following types of VABs.

- Recreational programs (e.g., Boys and Girls Club, Family YMCA memberships)
- Backpacks, diapers bags, or other supplies that support life transitions
- Caregiver supports
- Enhanced non-medical emergency transportation to parenting classes and other supports for social drivers of health

Provider Network

The Division seeks feedback on any approaches that it should consider for building, maintaining, and training a high-quality behavioral health workforce serving youth through the development of a new SMCP, including approaches that have been successful in other states. This includes any requirements for billing support and training through the SMCP, provider reimbursement models or structures, successful utilization management approaches, or value-based payment designs that support the growth and development of the provider infrastructure and reward high performing providers for quality and outcomes.

The Division also seeks specific feedback on the pros and cons of requiring the SMCP to honor Nevada Medicaid's current fee schedule for reimbursement to network providers that deliver critical behavioral health services. In other words, the Division is considering whether it should require the SMCP to pay, at a minimum, no lower than the state's current Medicaid fee schedule to qualified providers for the delivery of behavioral health services to this child population.

Response: Medicaid providers that serve children and youth with behavioral health needs and substance use disorders and those interacting with the child welfare system should ideally have specific training to help address their unique and specific needs. We would encourage the Division to consider provider network quality standards that include requirements that providers have the training and/or experience needed to serve the needs of children, youth, and families in the SMCP including appropriate training in trauma-informed care, family driven, and youth guided approaches to care planning, and systems of care. In addition, the SMCP's care managers should be required to have similar training and experience.

While telehealth is not the solution for all, it is an important solution for many. As a result, where clinically appropriate, we recommend the Division clearly define telehealth as a modality for delivering care and afford the SMCP the flexibility to enhance their provider network with telehealth practices so that members maintain choice, access, and ultimately help improve their overall satisfaction. This could include provider-to-provider or interprofessional consultations, including e-consults, allowing providers to share expertise and offer guidance on complex cases enhancing access and quality of care. To support interprofessional consultations, the Division would need to authorize the codes to allow providers to bill for collaborative care activities.

School-based health centers (SBHCs) offer a unique opportunity to provide accessible and comprehensive health care services to children and adolescents. SBHCs can help improve overall health care quality and outcomes, especially for children with special health care needs. School-based providers are also on the front line of addressing other social and economic factors that affect children and young adults, including food insecurity, depression, bullying, housing instability, and more. By incorporating the services provided by SBHCs into managed care, these providers can be provided with additional support from the SMCP including the potential for engagement in value-based payment arrangements providing further financial support and stability.

Beyond these considerations specific to the workforce associated with serving the population managed by the new SMCP, we offer the following ideas that could help build and maintain a workforce to serve both this specific population as well as positively impact the broader Medicaid population.

- **Tiered payment structures for high-performing providers**. Retaining the current workforce is an important part of a strategy to build and maintain provider workforce capacity in the state. When tied to performance targets, a tiered payment structure may encourage participation and identify areas of quality improvement. This structure may also encourage providers to improve their care offerings by investing in technology and infrastructure that enhances the member experience and the care delivery model and can be especially impactful in areas with particularly significant workforce shortages.
- **Community reinvestment payments for workforce development strategies**. We encourage the Division to re-imagine their community reinvestment program to address provider workforce gaps related to the needs of the SMCP covered population. This could take the form of a scholarship to recruit and retain specialists wherever community need is highest.
- **"Grow Your Own" initiatives for high school graduates to gain certification and/or licensure for much-needed clinical and non-clinical capabilities in their own communities**. Conceptually, this idea is to give young adults a career pathway in the health care system, with a high wage and ability to stay close to their hometown. We recommend the Division work with the community college system, technical colleges, the Nevada System of Higher Education (NSHE), and leading medical professional associations. We also recommend the Division work with philanthropic partners that may help fund the development of a curriculum, scholarships to offset the cost of a program, and help convene the variety of stakeholders and advocates who may wish to support this kind of venture.
- **Assess current certification and licensing requirements for certain provider types and the impact on access.** More flexible certification and licensure regulations, along with sufficient reimbursement rates, can help to ease provider availability and access particularly

for rural and frontier members.

Ensuring that a fee schedule is reflective of the costs to provide care is necessary to encourage providers to participate in the Medicaid program. However, across-the-board fee schedule increases may result in excessive capacity in some locations for lower intensity services while gaps in higher intensity services remain unmet. Additionally, rural or frontier communities may continue to experience a shortage of providers despite the increased fee schedule. As a result, we would encourage the Division to collaborate with the SMCP to assess the state workforce, behavioral health access, and service gaps in order to develop a comprehensive understanding of where gaps exist and enable the deployment of targeted strategies – policy, program design, provider supports, and funding solutions - to address these gaps effectively.

Payment above the fee schedule should be accompanied by quality and outcome expectations. Providers who receive higher reimbursement rates should be held to standards that ensure they deliver high-quality care, timely access, and achieve positive outcomes for their patients. Specific opportunities to target or reward specific program outcomes include timeliness of first appointment, enhanced initial intake, and supported referral/warm handoff.

Collaboration with Child Welfare, Courts, Counties, Schools, and Other Child-Serving Entities

The Division seeks feedback and input on any requirements and/or best practices that it should consider for the SMCP to ensure cross-sector collaboration and partnership develops and is maintained in the best interest of the children to be served by the SMCP. It also seeks feedback on ideas for ensuring transparency with child-serving partner entities with respect to the level of support and collaboration that child-serving entities should expect from the SMCP and options for reporting non-performance. Furthermore, the Division is considering whether it should implement a SMCP coordinating committee that consists of regional representatives from various systems and sectors that serve children in addition to family representatives that would serve as a community advisory committee for the SMCP.

Response: Coordinated communication and regular engagement creates strong relationships between systems, helps support timely sharing of information and completion of needed assessments, provides opportunity for more efficient troubleshooting, and strengthens operational familiarity across all stakeholders. All of the stakeholders—the biological, foster, and adoptive families, the providers, the court and school systems, private agency caseworkers, the SMCP, and the state— should be committed to cross-sector and system engagement through an on-going dialogue including using easily accessible means to participate and allowing individuals to self-advocate. By actively partnering, solutions can be designed that help children and youth improve their lives and chances for success. Importantly, children and youth currently receiving services or who have transitioned to adulthood should be engaged early and often in program development, implementation, and evaluation.

To support cross-sector collaboration and an accountable system of care, the Division should create an environment where regular communication and check-ins between the SMCP and cross-sector agencies and partners, including child welfare and juvenile justice case workers are possible and expected. The SMCP should be authorized to serve as the single point of contact related to the medical, behavioral, and functional needs of this population for all systems and individuals engaged in their care and support. To reduce complexity for both the children and youth and those

supporting them, providing the SMCP with this responsibility helps to coordinate their care and helps them navigate the health care system. The SMCP can remove uncertainty in accessing services and supports from each of the systems they are engaged with and create an anchor to address their needs more effectively. The SMCP care manager will act as a hub for the child's holistic plan of care to ensure successful delivery of services that can meet their unique needs.

Though regular in person engagements are appropriate, virtual/telephonic opportunities should be supported by maximizing technological capabilities. The Division should require an entity interested in serving as the SMCP to provide a solution to how to establish a universal portal that can tie into the state's electronic Health Information Exchange (HIE) and that is accessible by caseworkers, the SMCP, caregivers, providers, and others supporting this population. By leveraging technology, administrative burden is decreased, ability for coordinated communication increases, and real time updates are available as contact information changes, placement moves take place, care needs are updated, etc. Integral to the success of this portal will be the use of data sharing agreements, clear security protocols, and the use of security profiles per unique stakeholder.

The school can be an important source of information about a child's well-being and a point of access to the services needed to address a child's health and educational challenges. In order to help coordinate care and avoid duplication of services, health plan care coordinators should be allowed to actively participate in school-related meetings with children, youth, and their families/caregivers and participate in the IEP/504 plan development. In addition, the rate setting process should include funding to support health plan engagement with schools and specific coverage of educational advocacy services, including involvement in the development of Individualized Education Plans (IEPs) and 504 plans.

Building consistency, trustworthiness, and transparency with all stakeholders means ensuring open and honest communication, explaining processes in a way that can be understood, and stating what cannot be done or what is not being done to the quality standards set by the SMCP and/or the Division. These principles should be core to the work of the health plan chosen to serve as the SMCP. We are supportive of the Division's idea of a coordinating committee to serve as an advisory committee for the SMCP and see that potential structure, and the public reporting of its work, as a key contributor to a transparent and accountable partnership between the SMCP and key cross-sector stakeholders. Given the SMCP's role as anchor stakeholder, responsibility for establishing and managing the committee should be with the SMCP with reporting expectations back to the Division.

Solutions to Managed Care Pitfalls

a. Performance: The Division is interested in implementing a public dashboard or tool for tracking the performance of the new SMCP and its network providers. The Division seeks feedback on this idea and the types of quality metrics or indicators that the public and stakeholders will find helpful if the Division implements such a public tool for the SMCP.

   Response: We applaud the Division for its desire for transparency and accountability and are supportive of a public dashboard or tool that tracks the performance of the SMCP. Based on our experience with performance dashboards in other states, we believe that the key to their successful implementation focuses on the selection of metrics and methodology that 1) align to the strategic goals of the Division, 2) can be reliably calculated, 3) have the ability to be compared against national benchmarks or a standard target for desired performance levels, and 4) are communicated to consumers in a clear and useful way. We

welcome the opportunity to work with the Division on establishing a public dashboard or tool that captures progress on the determined set of performance measures as we collectively work towards supporting increased access to community-based services and decreased utilization of institutional or congregate placements for children with behavioral health needs.

b. Profit v. Non-Profit: The Division seeks feedback on whether it should prioritize non-profit over for-profit vendors to serve as the SMCP in the scoring or evaluation process of the procurement. Please explain your answer and the pros and cons of your recommended approach.

Response: We recommend that the qualifications of an entity to serve as the SMCP should be based on:

- Understanding of and expertise in serving the population.
- Current relationships and partnerships with providers and key stakeholders engaged with and serving the SMCP population.
- Experience serving Nevadans and an understanding of the unique needs of the communities across the state; and
- Financial stability and oversight necessary to ensure sustainability and predictability of the program

c. Vendor Payment: The Division seeks feedback on the level or percentage of the medical loss ratio that seems appropriate for this population, and if there are recommendations on whether the Division should seek to secure the state's share of the remittances to fund additional bonus payments for the SMCP or providers that are designed to drive greater performance and outcomes.

Response: We offer the following recommendations for the Division on implementation of the MLR for this program including the level or percentage and use of the remittances.

- Implement a MLR with remittances in a stepwise approach, holding the SMCP harmless for the first year to provide a 'stress test' of the MLR methodology and work closely with the plan to understand financial performance and the feasibility of the MLR structure throughout the year.
- For the second year, the Division could consider adopting a community reinvestment mechanism for paying back MLR remittances. Several other states, including North Carolina and Tennessee, have implemented a similar approach.
- Ongoing, the Division should work with the SMCP to reassess the MLR calculation to ensure all activities are appropriately defined. We are ready to work with the Division to determine the MLR threshold that makes the most sense for the SMCP served population.

With regards to the Division's use of the MLR remittances to fund additional bonus payments for the SMCP or providers, we would support this approach, but as noted above, also suggest the Division consider adopting a community reinvestment mechanism as other states have done.

d. Community Reinvestment: The Division seeks feedback on this proposal and the types of activities it should require such investments be spent on by the SMCP pending the level of profits driven by the program.

Response: As stated above, we recommend the Division consider adoption of a community reinvestment approach when considering the use of MLR remittances. North Carolina allows its health plans to direct MLR remittances towards high-impact initiatives that improve health outcomes and the cost-effective delivery of care. Health plans must submit proposals of these investments for approval by North Carolina's Medicaid agency and they must align with the state's Quality Strategy. Tennessee similarly allows its health plans to develop a community reinvestment plan that, subject to state approval, allows the health plan to reinvest the MLR remittance back into the community.

Any reinvestment strategy should be subject to approval by the Division, in line with state-established program goals and initiatives relevant to the SMCP. And the Division should, at the outset, apply clear guardrails and evaluation criteria to ensure investments are effective and targeted. We have significant expertise in community reinvestment program design and implementation across several of our markets and can be a strong partner to the Division in developing a community reinvestment program.

e. Quality Withhold Payments: The Division is considering a withhold arrangement for payment that would allow the Division to "withhold" a portion of the vendor's monthly capitation payment. The amount withheld would become available to the SMCP if it meets certain performance targets or quality metrics. The Division seeks feedback on this approach and the types of performance or quality metrics it should consider for this withhold payment.

Response: We are supportive of the use of quality withhold arrangements to measure performance and drive improvement. Based on our experience with the implementation of quality withholds in other markets, the key to the use of quality withholds to drive improved care delivery focuses on the selection of metrics and methodology. In addition, withhold metrics and targets should be chosen to ensure minimum standards are met and improved performance is incentivized. We encourage the Division to take an incremental approach to implementing the withhold arrangement, beginning with operational metrics and expanding to include traditional quality/HEDIS/CAHPS metrics as clear baseline performance and targets can be set for this specialty population. Our recommendation is to include measures such as well-child visits and first-line psychosocial care for children and adolescents on antipsychotics. Finally, it is a best practice to incorporate the withhold expectations into the rate setting process and that rates set are actuarially sound both considering the total withhold amount and the achievability of the targets in the withhold arrangement.

Hello, I am responding to the RFI titled: Solicitation of Public Input Regarding the Implementation of a New Specialty Managed Care Plan for Certain Children and Youth Populations

Connect Our Kids is a 501c3 nonprofit that provides tools and trainings to help Medicaid providers, child welfare professionals and others to support the mental, emotional, and relational health of child welfare affected (or at risk) children and families. We are currently working with the Medicaid provider in another state to get foster children connected to family members so that they can leave high-cost residential care facilities.

Addressing Item 3, Benefit Set: With regard to the "whole-child" approach and "what would be most valuable to supporting the care and needs of this child population and their families and/or caregivers":
Relational health — the strength of one's supportive meaningful relationships — is foundational to all other health, but is often overlooked because it can be invisible. We recommend that relational health be explicitly centered in Nevada's Medicaid approach for the child populations of interest. This can be done by requiring that Medicaid case managers and relevant providers are always attentive to the important relationships in the member's life, and how those relationships are impacting their current challenges. Connect Our Kids (https://connectourkids.org/) provides training on the importance of relationships, and provides tools to support the awareness, safeguarding, and growth of those relationships. This is a particularly devastating issue in the context of foster care, where children and families can have their relationships severed, causing great harm to all involved. Connect Our Kids helps keep those relationships intact, preferably with families staying physically together, but also and especially if children must be temporarily cared for outside their own home.
Multiple studies have shown that, other than in the most extreme cases of abuse, children do best with their own imperfect parents, and if out-of-home care does become necessary, children in kinship placements are more likely to express satisfaction with their placement and graduate from high school, and less likely to exhibit difficult or dangerous behaviors, run away or be trafficked, and ten times less likely to be re-abused. A study of siblings separated, with one sibling taken into foster care, and another sibling who stayed with biological parents, found that the siblings raised in foster care had twice the rate of attempted or completed suicides.
Medicaid is crucial to this issue, as Medicaid can be the driver for the supports that allow families to stay together when they are struggling and child safety becomes a concern. Connect Our Kids is focused on this issue.

Addressing Item 5, Collaboration with Child Welfare, Courts, Counties, Schools, and Other Child-Serving Entities: Connect Our Kids has experience working in states and collaborating with multiple child-serving entities. Acknowledging the collaboration challenges already noted in this Solicitation, we also recommend that Nevada also consider that the collaboration challenges go both ways. The SMCP may be ready and willing to collaborate, but the other party may not feel a need to do so lacking some driver to prioritize this collaborative effort. Anything that Nevada can do from the state level to increase the collaboration from both directions will help enormously. The ideas of SMCP coordinating and community advisory committees are good ones.

From the perspective of selecting an SMCP, we recommend that an important criteria for selection be a demonstrated eagerness to collaborate, especially with innovative mission-driven companies in this space. Evaluation of these mission-driven companies should also include assessment of their eagerness to collaborate. Some to look at, in addition to Connect Our Kids (https://connectourkids.org/), are Your Case Plan (https://www.yourcaseplan.com/), Psyche Care (https://www.psychecare.org/), Peers.net (https://peers.net/) and HereNow Health (https://www.herenow.health/). There are great ideas at work in the small business space, and you have the exciting opportunity to tap into these to allow Nevada to leap forward in providing high-quality support to your vulnerable populations.

Addressing Item 6, Solutions to Managed Care Pitfalls:

b. Profit vs. Non-profit. Rather than this dichotomy, we recommend that Nevada carefully consider each company on an individual basis, based on their demonstrated commitment to the values of interest to Nevada in this contract, and select those that clearly share the mission and values of this effort to improves the lives and outcomes for Nevada's most vulnerable.

c. Vendor Payment. While acknowledging that this can be a complicated space, we would like to raise the concern that medical loss ratios can cripple efforts to implement beneficial and innovative scalable solutions that aren't appropriate for individual reimbursement codes.

Thank you for the opportunity to give input on this decision. I am available for any follow-up questions you may have.

To the Nevada Division of Health Care Financing and Policy:

Thank you for soliciting input in the design and development of the State's Specialty Managed Care Plan (SMCP) to support the delivery of Medicaid covered services to children with behavioral health needs.

YourCasePlan is grateful for the opportunity to provide input on Nevada's Specialty Managed Care Plan solicitation. YourCasePlan is a secure, vendor-agnostic collaboration platform that unifies data and workflows across Medicaid, court systems, school systems, and child welfare to ensure holistic, child-centered, coordinated care. Our leadership consists of foster parents who have worked for reunification and health plan leaders who have worked to improve managed care entities. We know firsthand that seamless, cross-sector collaboration is the linchpin of effective, child-and-family-centered care.

We submit the attached feedback on Items #2 and #5, focused on strengthening local care management structures and enabling seamless cross-sector collaboration to improve health outcomes and quality of life for Nevada's most vulnerable children and youth.

Thank you for the opportunity to provide input on the development of the upcoming SCMP. We are available for any questions or follow-up you may have. We look forward to connecting with you.

YourCasePlan Response to Solicitation of Public Input Regarding the Implementation of a New Specialty Managed Care Plan for Certain Children and Youth Populations

Introduction

YourCasePlan thanks you for the opportunity to provide input on Nevada's Specialty Managed Care Plan solicitation. YourCasePlan is a secure, vendor-agnostic collaboration platform that unifies data and workflows across Medicaid, court systems, school systems, and child welfare to ensure holistic, child-centered, coordinated care. We submit the following feedback on Items #2 and #5, focused on strengthening local care management structures and enabling seamless cross-sector collaboration to improve health outcomes and quality of life for Nevada's most vulnerable children and youth.

Item #2: Care Management Approach

YourCasePlan submits that the most successful Care Management approach is one in which care management is delivered by high-trust, local community providers who have established relationships with the target population. Successful care management is naturally collaborative, with a comprehensive view of the patient—not just clinically—but socially as well.

Based on our review of successful implementations elsewhere (e.g., New Jersey's Children's System of Care), Nevada would benefit most from establishing a statewide CME with regional subcontractors. This hybrid model ensures clear governance and quality control from a centralized care management hub. It also harnesses trusted local providers for direct care coordination. This approach achieves high-engagement with the target population by meeting them where they are both clinically and socially and walking alongside them in their healthcare journey. Finally, this hybrid CME model also directly addresses Nevada's core DOJ-driven priorities to (1) expand quality and access to care by broadening community-based care options through incorporating trusted, local providers, and (2) enhances discharge planning by engaging culturally competent providers with direct first-hand knowledge of local community resources and assets in reunification planning, ensuring smoother and safer discharge transitions.

Key features for successful implementation:

- Clear, uniform standards for all subcontractors.
- Single statewide technology platform to enable consistent care planning and coordination across regions.
- Strong centralized governance with defined regional flexibility.
- Regular stakeholder forums to ensure alignment, transparency, and continuous improvement.

Real-world Example (Technology):

Neutral-party technology platforms (like YourCasePlan) specifically support hybrid CME approaches by enabling standardized workflows, real-time data sharing, role-based collaboration, and seamless subcontractor management. Platforms of this type have successfully accelerated care coordination, reduced administrative duplication, and significantly improved cross-system outcomes in analogous state programs.

Conclusion:

Adopting a hybrid CME model with clear centralized governance, regionally trusted subcontractors, and neutral-party technology infrastructure positions Nevada to achieve its goal of statewide, high-quality care management.

Item #5: Collaboration with Child Welfare, Courts, Counties, Schools, and Other Child-Serving Entities

YourCasePlan agrees with Nevada's emphasis on the need for "shared systems, technologies, and processes" and "strong collaboration and partnership" across all child-serving agencies to "identify and overcome roadblocks and address gaps" in support of children with behavioral health needs. To meet this need, we recommend a neutral-party, standards-based collaboration layer that seamlessly binds the SMCP with local case-management, child welfare, juvenile justice, courts, and schools—ensuring the cross-sector collaboration the Division seeks is both developed and maintained in the best interest of Nevada's children.

YourCasePlan's leadership believes this not only professionally, but also personally—we've lived it. We are foster parents who have worked for reunification. We are former health plan leaders who have worked to improve systems from within managed care entities. And so we know firsthand that seamless, cross-sector collaboration is the linchpin of effective, child-centered care. In direct response to the RFI's call for "shared systems, technologies, and processes" and a "vendor that is willing to partner and problem-solve with all stakeholders," we suggest the following solutions:

1. Shared Systems & Technologies

- Unified Collaboration Hub: One secure, cloud-based platform where all partners—SMCP, DCFS, courts, schools, juvenile justice—access the same child record, care plan, and service authorizations.
- Vendor-Agnostic Platform: Built for child-centered care that encourages collaboration and transparency.

2. Shared Processes & Workflows

- Configurable Workflow Templates: Prebuilt, best-practice pathways (e.g., court-to-case-manager referrals, IEP coordination, discharge planning) that each agency follows end-to-end.

- Closed-Loop Referral System: Stakeholders can assign tasks to the right case manager or provider and see them all the way through to completion, eliminating manual tracking.

3. Partnership & Problem-Solving Culture

- Virtual Steering Committees: YCPs startup culture is known for its collaborative co-building approach—so DHS case management, Medicaid MCOs, local agencies, judicial liaisons, and family advocates have a seat at the table to create solutions together.

4. Transparency & Performance Reporting

- Role-Based Dashboards: Each agency sees only its own KPIs (e.g., referral closure times, missed-appointment rates) plus system-wide metrics for accountability.
- Public Dashboard Support: YCP can power configurable, public-facing dashboards that surface aggregate, de-identified performance metrics—such as referral closure rates, average time-to-service, and SLA compliance—for all stakeholders and citizens.

Conclusion:

By embedding these solutions in a neutral-party, standards-based platform—and grounding every feature in the lived experience of child-welfare and managed-care veterans—YourCasePlan meets Nevada's RFI ask for "strong collaboration and partnership" across all child-serving systems. Together, we can break down silos, close service gaps, and create a truly child-centered system of care.