

Children's Behavioral Health Transformation Implementation Plan



*Nevada Health Authority
Division of Nevada Medicaid*

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Introduction

On January 2nd, 2025, the State of Nevada entered a [settlement agreement](#) with the United States Department of Justice. This agreement addresses [findings from a 2022 investigation](#) that found Nevada to be out of compliance with provisions of the Americans with Disabilities Act. The Children’s Behavioral Health Transformation Implementation Plan outlines the state’s planned efforts to achieve compliance with the Settlement – and to achieve a successful transformation of Nevada’s Medicaid behavioral health system for youth.

The Division of Nevada Medicaid, which falls within the newly established Nevada Health Authority, is designated by the State as the leading agency for this transformation effort. However, the transformation project and implementation plan are the product of a strong, collaborative partnership with sister state agency partners within the Nevada Health Authority and the Department of Human Services, including the Division of Child and Family Services, Division of Public and Behavioral Health, Division of Social Services, and Aging and Disability Services Division.

The vision for this transformation is for Nevada children to have access to the behavioral health services they need to live and thrive with their families and in their communities. Specifically, this effort is focused on youth served by state systems and/or eligible for Medicaid coverage, defined by the settlement agreement as the “Focus Population.” The guiding principles of Nevada’s transformation include a clear, consistent focus on youth and families, a local, community-driven approach, and strong collaboration and accountability held by all partners in this effort.

In summary, Nevada’s transformation effort centers on a Specialty Managed Care Plan that will provide integrated medical, behavioral, and pharmacy services coverage for youth with complex behavioral health needs. This plan will provide enhanced care coordination and robust coverage of behavioral health services across the care continuum, from home- and community-based services to acute care. This effort requires the development of new Medicaid reimbursable benefits, the fostering of a robust, high quality provider network, and coordination between all child-serving programs across the state.

This implementation plan documents the state’s path to achieving compliance over the next five years, in coordination with youth and family stakeholders, county and state agency partners, and other community members. This plan reflects the metrics of success evaluated by the Independent Reviewer, as required by the Settlement Agreement.

Timeline

There are a range of crucial timelines at play to achieve compliance with the Settlement within five years. These include various Settlement-required reporting items timeline noted in **Figure 1** below.

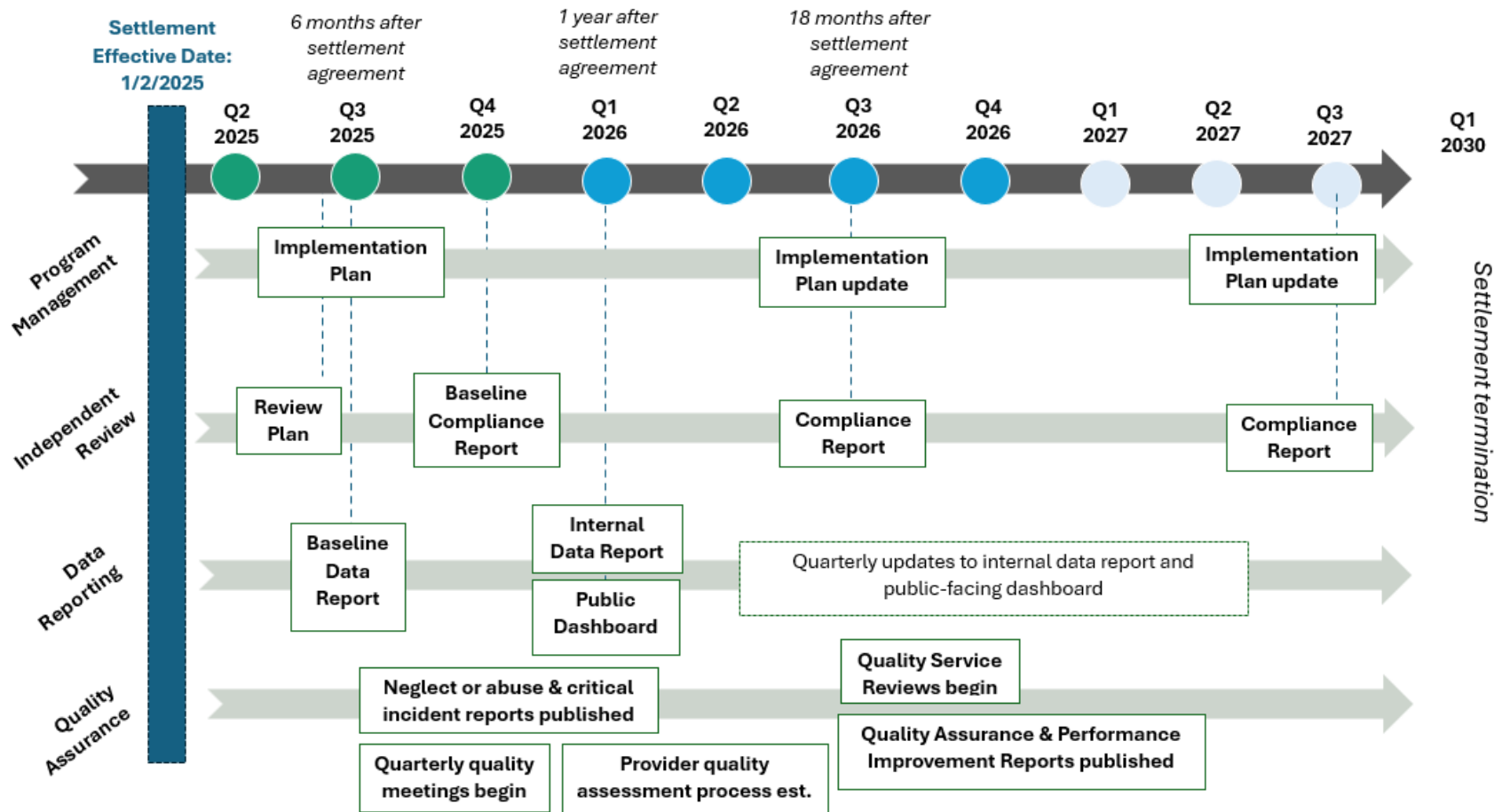


Figure 1: Timeline of Settlement Requirements

The broader Transformation timeline spans the development of Medicaid benefits and statewide regulations and policy over the next two years, in preparation for the launch of the Specialty Managed Care Plan on **January 1st, 2027**. Provider workforce and quality assurance efforts will be ongoing throughout the course of the agreement, and will require continuous effort to maintain after compliance has been achieved. These efforts are summarized in **Figure 2** below.

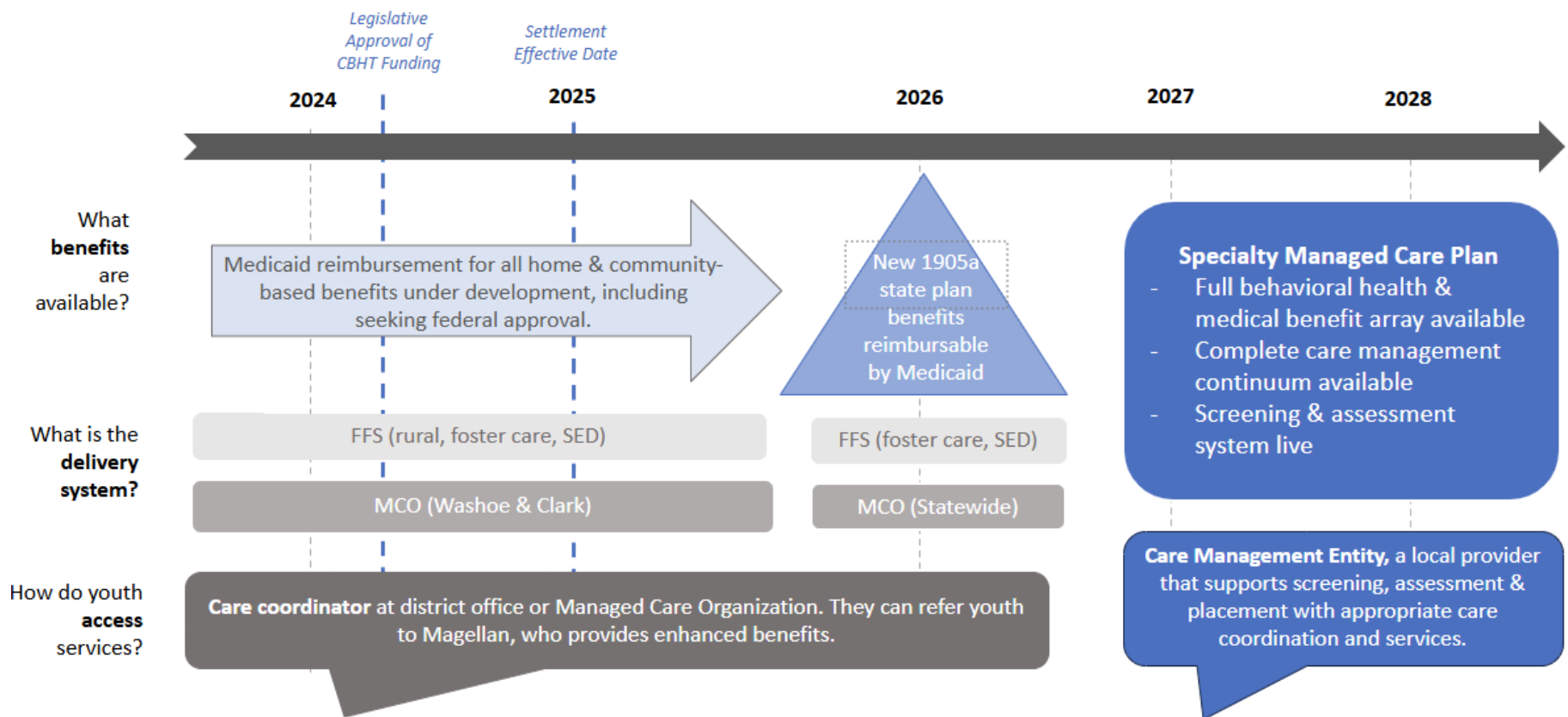


Figure 2: Timeline of Transformation Project

Path to Compliance: Summary

The following table provides a summary of the State's planned compliance status by each section of the settlement agreement. Highlighted cells indicate the status of the State's compliance at the noted year. This framework utilizes three distinct phases, as defined by the University of Connecticut Innovations Institute's Implementation Science Framework (II-ISF).

Compliance Indicator Key	
Phase	Description
Maintenance	Focus on assessing whether the new program is fully embedded in the community and ensuring its long-term sustainability <i>Ex: Ongoing review of policy and reimbursement models for Family Peer Support to ensure access to high quality care for all eligible families.</i>
Implementation	Focus on piloting, initial implementation, scaling up, and refining the program as it moves toward broader application. <i>Ex: Launch of a new Medicaid benefit and provider type for Family Peer Support services.</i>
Pre-Implementation	Focus on all necessary groundwork before launching a program, including research, stakeholder feedback, and policy drafting. <i>Ex: determining Federal authorities necessary to provide coverage for the Family Peer Support benefit.</i>

DOJ Settlement Section	Compliance: Jan 2026	Compliance: Jan 2027	Compliance: Jan 2028	Compliance: Jan 2029	Compliance: Jan 2030
Section 3: Screening and Assessment to identify children in focus population.	Statewide screening and comprehensive assessment tool selected, process developed and piloted.	Launch of statewide screening & comprehensive assessment process.	Ongoing monitoring and quality improvement to ensure compliance.		
Section 4: Service Planning and Coordination.	Wraparound benefit developed and piloted per settlement requirements and national best practices.	Tiered wraparound and intensive care-coordination benefits launched by Specialty Managed Care Plan (SMCP).	Ongoing monitoring and quality improvement to ensure compliance, with a strong focus on provider workforce development for wraparound services with Care Management Entities.		
Section 5: Home and Community Services.	All new and enhanced 1905a state plan benefits are available in Medicaid state plan and policy, upon Federal approval.	Final 1915i state plan benefits are launched in alignment with the SMCP.	Ongoing monitoring and quality improvement to ensure all services are delivered in accordance with evidence-based practices and are available to youth in the focus population.		
General requirements					
Mobile crisis and stabilization	Medicaid state plan covers mobile crisis response as well as “Designated Mobile Crisis Team” (DMCT) services designed to align with SAMHSA guidelines. Strengthening of 988 statewide crisis line and dispatch is ongoing.	Comprehensive reimbursement reform is launched, subject to federal approval. Ongoing strengthening of state’s crisis response network through grant funds and provider training.	Statewide network of providers offering a range of crisis services to Medicaid and non-Medicaid enrollees. Ongoing performance monitoring is conducted across all phases of the crisis response continuum to ensure key performance standards are met.		
Intensive in-home services	All new and enhanced benefits included within “Intensive in-home services” are available in Medicaid	Respite and care coordination benefits	All intensive in-home services covered for Focus Population members via SPMC, in accordance with settlement requirements.		

DOJ Settlement Section	Compliance: Jan 2026	Compliance: Jan 2027	Compliance: Jan 2028	Compliance: Jan 2029	Compliance: Jan 2030
	state plan and policy, upon Federal approval, except for respite and wraparound services.	launch in alignment with SMCP go-live.	Ongoing efforts to increase provider workforce and availability of services through new Specialty Managed Care Plan.		
Psychiatric services and medication management	These services are currently covered by Medicaid via the 1905a state plan. Ongoing efforts to increase utilization of services statewide and in fidelity with evidence-based practices.	SMCP to ensure continued and growing access to these services, including via telehealth and in-home where feasible. Ongoing monitoring of quality and compliance.			
Section 6: Diversion and Transition	Wraparound benefit remains under development. Youth in the Focus Population are eligible to participate in wraparound facilitation via the Connect Nevada pilot program.	Wraparound benefit is covered by Medicaid and delivered via Care Management Entities (CME) as part of the SMCP. Medicaid policy includes a robust collaborative model to ensure appropriate placement, diversion, and transition from PRTF setting.	Wraparound and ICC services covered by Medicaid for eligible Focus Population members and delivered by regional CME. Clear workflow for diversion and transition outlined with PRTF facilities. Ongoing quality assurance and monitoring to ensure compliance from Specialty Managed Care Plan.		
Section 7: Stakeholder Engagement	Sister agency forum and Medicaid Advisory Working Group launched in Q4 2024, with a focus on centering youth and family perspectives, as well as those of a range of providers and community partners. Ongoing Community Forums, website improvements, public workshops and hearings, and other community communications are utilized to ensure strong collaboration and feedback loops on all program and policy changes.				

DOJ Settlement Section	Compliance: Jan 2026	Compliance: Jan 2027	Compliance: Jan 2028	Compliance: Jan 2029	Compliance: Jan 2030
Section 8: Provider Workforce Development	Partnerships established with existing provider workforce efforts. Assessment of training needs conducted by the Workforce Development Office within the Nevada Health Authority.	Workforce development plans reviewed and published. Execution begins. Launch of “Center of Excellence” model to ensure provider training needs are met.	Ongoing execution and adjustments to workforce development plans. “Center of Excellence” is scaled statewide and available to all relevant stakeholders. Ongoing provider quality monitoring and training.		
Section 9: Quality Data & Analysis	Baseline and quarterly data reports are published on an ongoing basis, and are supplemented by public dashboard reporting. Additional required reports are published per required cadence.				
Section 10: Quality Service Review Process	QSR process begins in Q2 2026 and follows all cadence, format, and content expectations of settlement, including a planned transition between the Independent Reviewer and State QSR team.				

Path to Compliance: Detailed Agreement Requirements

The following table notes the specific Evidence for Compliance and Implementation Activities associated with each item within the Settlement Agreement. The Implementation Activities align with the summary table above, which reflects the year-by-year status of the implementation plan.

Section 3: Screening and Assessment to Identify Children in Focus Population

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
1.	The State will oversee a toll-free phone line and website where individuals can receive information about Home- and Community-Based Services and through which Children and families can request to be connected for screening for such services. The phone line will be staffed between 8 am and 9 pm, 7 days a week. Urgent website requests for Home- and Community-Based Services will be responded to as soon as practicable but no later than within one business day; all other website requests will be responded to within 3 business days. The State will develop protocols to ensure that any calls from Children and Families experiencing an active crisis are transferred to the crisis hotline described in this Agreement. The toll-free phone line will be available to all Children under age 21 and their Families, regardless of Medicaid eligibility and regardless of whether the	• State will provide written description of phone number, website, and contracted authorities who have operational responsibility and oversight • State protocols • State performance monitoring/data reports • Marketing, outreach, and educational materials • Interviews of staff • Interviews of children and families who have used the phone line.	Protocols developed by July 1, 2026. Website and phone line operational by January 1, 2027. Beginning no later than six months following website and phone line launch, State will review call and website data monthly to assess compliance with response times and referrals to crisis hotline.

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
	Children fall within the Focus Population.		
2.	The State will adopt a set of behavioral health screening tools that are nationally recognized or validated tools that are brief, mental health specific, and developmentally appropriate.	• State will provide a list of adopted screening tools documenting full implementation and utilization of the screening tools • The adopted screening tools. • State policy or directive stating required use of tool(s)	Screening tools identified and approved by Fall 2026. Medicaid Services Manual outlining policy published by Fall 2026. Monitoring plan under development; will provide detail in subsequent Implementation Plan.
3.	The State will establish and monitor compliance with timeliness standards for completion of screenings. The timeliness standards will be established by the State after receiving and considering feedback from community partners, service providers, the United States, the Centers for Medicare & Medicaid Services (CMS), and the Independent Reviewer.	• State will provide policy and procedures documents • State performance monitoring/data reports • Other documentation of monitoring • Documentation of receiving and considering feedback on the standards	Medicaid Services Manual outlining policy published by Fall 2026. Beginning no later than six months following the implementation of screening standards, the State will launch a monitoring program to ensure compliance with State timeliness guidelines. This monitoring plan is under development and will be detailed in subsequent updates to the Implementation Plan.

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
4.	The State will ensure that a screening tool is completed for any Child not already known to be receiving behavioral health services when the Child begins receiving services through State of Nevada Department of Health and Human Services child welfare, juvenile justice, or developmental services programs.	• State policies • State performance monitoring/data reports • Quality Service Reviews (QSRs)	State policies updated and published by January 1, 2027. Data sharing agreements developed between state agencies for monitoring of compliance established by January 1, 2027.
5.	The State will develop collaborative agreements with county entities so that the counties use the screening tools adopted pursuant to this Section to screen Children who enter a juvenile detention facility or foster care shelter within established timeliness standards guidelines. The State will monitor compliance following establishment of these collaborative agreements.	• State will provide documentation of fully executed collaborative agreements • State performance monitoring/data reports • Other documentation of monitoring	Collaborative agreements in place by January 1, 2027. Data sharing agreements developed between state agencies for monitoring of compliance established by January 1, 2027.
6.	The State will establish a new requirement that Children within its Medicaid program receive periodic screening using the screening tool(s). The State will monitor compliance following establishment of this requirement.	• State will provide policy and procedure documentation regarding screening tools. • Performance monitoring/data reports • QSRs	Medicaid Services Manual outlining policy published by Fall 2026. Compliance monitoring embedding into EPSDT monitoring.
7.	The State will establish and monitor compliance with protocols for referral for a screening if a Child or Family requests Home- and Community-Based Services through the toll- free line or website.	• State protocols • State performance monitoring/data reports • Other documentation of monitoring • QSR	Protocols will be established by January 1, 2027. Beginning no later than six months following website

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
			and phone line launch, State will review call and website data monthly to assess compliance with response times and referrals to crisis hotline.
8.	The State will establish and monitor compliance with requirements to conduct Comprehensive Assessments for Medicaid-eligible Children in the following populations:	• State will provide policy and procedure documents and data reports • State performance monitoring/data reports • Other documentation of monitoring • QSRs	Medicaid Services Manual outlining policy and timeliness standards to be published and adopted via Public Hearing by Fall 2026.
	a. Children who have been referred to or sought authorization for Residential Treatment Facility services;		This population will be mandatorily enrolled in the Specialty Managed Care Plan – State will monitor plans’ compliance with arranging for a comprehensive assessment.
	b. Children who receive Mobile Crisis Response and Stabilization Services;		State will track referrals made by mobile crisis teams for comprehensive assessments.
	c. Children who have been admitted to a Hospital for treatment of a Behavioral Health Disability;		This population will be mandatorily enrolled in the Specialty Managed Care Plan – State will monitor plans’ compliance

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
			with arranging for a comprehensive assessment.
	d. Children who have sought care in an emergency department for treatment of a Behavioral Health Disability; and		This population will be mandatorily enrolled in the Specialty Managed Care Plan – State will monitor plans’ compliance with arranging for a comprehensive assessment.
	e. all other Children whose screening indicated a need for further assessment.		
9.	For Children who are not Medicaid-eligible but whose screening indicated a need for further assessment, they will be referred for such assessment.	• State will provide policy and procedure documents • QSRs	State will publish guidance by Fall 2026.
10.	The State will establish and monitor compliance with timeliness standards for completion of Comprehensive Assessments for Medicaid-eligible Children. The timeliness standards will be established by the State after receiving and considering feedback from community partners, service providers, the United States, CMS, and the Independent Reviewer.	• State will provide documentation of meeting dates, agendas, and minutes documentation of receiving and considering written comments • Documentation of the engagement of community partners, providers, DOJ, and CMS • data reports • QSRs	Timeliness standards developed and public comment complete by Fall 2026. Medicaid Services Manual outlining policy published by Fall 2026. Performance monitoring will be part of State oversight of Specialty Managed Care Plan

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
11.	The Comprehensive Assessment for Medicaid-eligible Children will be conducted by a Qualified Mental Health Professional.	• State policy or protocol • QSRs	Medicaid Services Manual currently reflects this requirement.
12.	If the Comprehensive Assessment for Medicaid-eligible Children identifies that a Child may have a co-occurring Intellectual or Developmental Disability (IDD), the Child will be referred for an IDD evaluation and services as needed.	• State policy or protocol • Data reports • QSRs	Medicaid Services Manual outlining policy published by Fall 2026. Nevada Medicaid will establish agreements with Aging and Disability Services Administration for referrals.
13.	Any component of the Comprehensive Assessment for Medicaid-eligible Children that has been completed within 90 days of the referral for Assessment need not be repeated unless there has been a significant change in condition or circumstance.	• State policy or protocol (re: significant change in condition or circumstance) • QSRs	Medicaid Services Manual outlining policy published by Fall 2026.
14.	The Family of a Medicaid eligible Child will be offered a referral to a Family Peer Support specialist agency or entity that employs Family Peer Support, through in-person and/or phone or internet contacts, if the Child is scheduled for a Comprehensive Assessment. The Family Peer Support specialist will be allowed to participate at the Child's or Family's request to	• State will provide policy and procedure documents • QSRs	Medicaid Services Manual outlining policy published by Fall 2026.

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
	assist in engaging the Family during the assessment process.		
15.	Medicaid-eligible Children will not be required to wait for the completion of a Comprehensive Assessment to access crisis stabilization services or any other urgently needed services that can be delivered prior to the completion of the Comprehensive Assessment.	• State will provide policy and procedure documents • QSRs	Medicaid Services Manual outlining policy published by Fall 2026.
16.	The screening process and Comprehensive Assessments will assist the State in identifying Focus Population Members.	• State will provide policy and procedures for screening process	State screening protocols developed by Fall 2026.
17.	The Focus Population for this Agreement will be all Children who meet the definition of Focus Population based on a qualifying event that occurred on or after the Effective Date. Children will remain in the Focus Population for at least one year following each qualifying event, except that Children who no longer meet criteria due to loss of Medicaid eligibility or turning 21 within one year of entering the Focus Population will exit the Focus Population upon that event.	• State will provide policy and procedures for defining focus population	Focus population eligibility will be outlined in Specialty Managed Care Plan Contract effective January 2027.
18.	Children who are assessed and found to not need the services in this Agreement, and Children who exit the Focus Population due to loss of Medicaid eligibility or turning 21, will be referred	• State guidance • QSRs	Medicaid Services Manual outlining policy published by Fall 2026.

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
	and linked to other behavioral health, social, and/or community services as needed.		Specialty managed care plan contract will include protocols for transition of care for children who transition off Medicaid or age out of eligibility.
19.	Children are not excluded from the Focus Population because of a co-occurring diagnosis of IDD.	• State Policy or procedures • QSRs	Policy will be outlined in the Specialty Managed Care Plan contract effective January 1, 2027.

Section 4: Service Planning and Coordination

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
20.	Children in the Focus Population will be offered Wraparound Facilitation. If they decline Wraparound Facilitation, they will be offered Intensive Care Coordination services as an alternative to assist the Child and Family with accessing available services, including available Home- and Community-Based Services. The State will track the reasons why families decline Wraparound Facilitation.	• State will provide policy and procedures for offering of Wraparound services • State performance monitoring/data reports • QSRs • Provider CQI/data reports	State will seek federal approval and develop Medicaid Services Manual policy effective January 1, 2027. Wraparound and Care Coordination will be provided to children enrolled in the Specialty Managed Care Plan beginning January 2027 or upon federal approval, whichever is later.

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
			State will review information from specialty managed care plan at least every six months to monitor compliance and reasons families decline Wraparound Facilitation.
21.	The State will expand capacity for Wraparound Facilitation and Intensive Care Coordination to support home and community living for Children in the Focus Population. To ensure capacity meets the needs, the State will monitor the accessibility and utilization of Wraparound Facilitation and Intensive Care Coordination to Children in the Focus Population and take appropriate action if those Children are not receiving Wraparound Facilitation or Intensive Care Coordination, according to their needs as identified in their Plans of Care.	• Wraparound capacity and utilization reports • State performance monitoring/data reports • QSRs • Provider CQI/data reports	State will require access benchmarks for services in the specialty managed care contract effective January 1, 2027. Performance monitoring on-going.
22.	The State will establish and monitor compliance with timeliness standards for service planning and delivery of Wraparound Facilitation and Intensive Care Coordination. The timeliness standards will be established by the State after receiving and considering feedback from community partners,	• State to provide wraparound policy and procedure documentation • State will provide documentation of meeting dates, agendas, minutes and the documentation of receiving and considering written comments • Documentation of the engagement of community partners, providers, DOJ, and CMS	Timeliness standards incorporating stakeholder feedback collected via Public Workshops, Working Group meetings, and Public Hearings will be finalized by Fall 2026.

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
	service providers, the United States, CMS, and the Independent Reviewer.	• State performance monitoring/data reports • Other documentation of monitoring • QSRs • Provider CQI/data reports	State will require timeliness benchmarks for services in the specialty managed care contract and Medicaid Services Manual, effective January 1, 2027. Performance monitoring on-going.
23.	The Wraparound Facilitator will assemble, convene, and support the Child and Family Team, who will manage the Plan of Care for Children in the Focus Population. The Wraparound Facilitator will be trained in the practices set forth by the National Wraparound Initiative and will lead the Child and Family Team in accordance with those practices. If these guidelines are revised or deemed outdated at any point during the pendency of this Agreement, the parties will meet and confer to determine whether to make any changes to these services.	• State will provide documentation of wraparound training requirements • State will provide policy and procedures • State performance monitoring/data reports • QSRs • Provider CQI/data reports	Medicaid Services Manual outlining provider and service standards, including training requirements, will be effective January 1, 2027. Performance monitoring on-going.
24.	The Wraparound Facilitator will work with the other members of the Child and Family Team to identify and ensure the provision of services and supports needed to successfully maintain or return the Child in the Focus Population to their Family and community.	• State to provide policy and procedures • QSRs • Provider CQI/data reports	Medicaid Services Manual outlining provider and service standards will be effective January 1, 2027.

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
25.	Wraparound Facilitators will have caseloads no greater than ten Children in the Focus Population per Wraparound Facilitator, with the exception of any short-term need to ensure that a Child and Family currently receiving Wraparound Facilitation does not experience a gap in this service due to staffing shortage.	• State to provide policy and procedures • QSRs • Provider CQI/data reports	Medicaid Services Manual outlining provider and service standards will be effective January 1, 2027.
26.	The Child and Family Team or Intensive Care Coordinator will be responsible for developing, monitoring, and updating a Plan of Care and Crisis Plan for the Children in the Focus Population. The initial Plan of Care will be finalized within 30 days of the first meeting between the Child, their Family, and the Wraparound Facilitator, or of the assignment of the Intensive Care Coordinator. The Child and Family Team will meet regularly and will update the Plan of Care and Crisis Plan at least every 90 days, and after any significant change in circumstance. For Children in the Focus Population with Intensive Care Coordination, the Intensive Care Coordinator will update the Plan of Care and Crisis Plan at least every 90 days, and after any significant change in circumstance.	• State policy and procedures • QSRs • Provider CQI reports	Medicaid Services Manual outlining provider and service standards will be effective January 1, 2027.
27.	For Children in the Focus Population with IDD, services related to IDD will be	• State policy and procedures • QSRs	Medicaid Services Manual outlining service

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
	included in the Child's Plan of Care and coordinated by the Child and Family Team or Intensive Care Coordinator.		standards will be effective January 1, 2027.
28.	The Child and Family Team, led by the Wraparound Facilitator, will work within the Team to resolve any differences among Team members regarding needed services, guided by the preferences of the Child in the Focus Population and their Family.	• State policy and procedures • QSRs	Medicaid Services Manual outlining provider and service standards will be effective January 1, 2027.
29.	The Child and Family Team or Intensive Care Coordinator will refer Children in the Focus Population to providers to initiate services identified in the Child's Plan of Care.	• State policy and procedures • QSRs • Provider CQI/data reports	Medicaid Services Manual outlining provider and service standards will be effective January 1, 2027.
30.	The Child and Family Team or Intensive Care Coordinator will ensure that Children in the Focus Population with an immediate need for intensive Home- and Community- Based services can access those services or any other similar services available in Medicaid to support home and community living while the Plan of Care is being developed.	• QSRs • State will provide policy and procedure documents	Medicaid Services Manual outlining provider and service standards will be effective January 1, 2027.
31.	The State will require that providers initiate services identified in a Child in the Focus Population's Plan of Care within the timeframes set forth in the established timeliness standards. The	• State will provide policy and procedure documents • QSRs • Provider CQI/data reports • Documentation of actions taken to ensure compliance	State will require timeliness benchmarks for services in the specialty managed care contract and Medicaid Services

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
	State will take appropriate action to ensure compliance is met.		Manual, effective January 1, 2027. State will review data from the Specialty Managed Care Plan to assess compliance.
32.	The State will ensure that Plans of Care are available to members of Child and Family Teams and appropriate crisis service providers, subject to the consent of the Family.	• State will provide policy and procedure documents • QSRs	Requirements will be outlined in Specialty Managed Care contract and Medicaid Services Manual, effective January 1, 2027.
33.	Recognizing the need to support Children in the Focus Population ages 18-20 during transition to adulthood, the State will offer the option of Assertive Community Treatment in place of Wraparound Facilitation or Intensive Care Coordination, where available and if appropriate.	• State will provide policy and procedure documents • State performance monitoring/data reports • QSRs • Provider CQI reports	Requirements will be outlined in Specialty Managed Care contract and Medicaid Services Manual, effective January 1, 2027.

Section 5: Home and Community Services

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
	General Requirements		
34.	The State will cover Home- and Community-Based Services in its Medicaid program to address the needs of the Focus Population. The State will expand capacity for Home and Community-Based Services to support home and community living for Children in the Focus Population. To ensure the capacity meets the need, the State will monitor the accessibility and utilization of Home- and Community-Based Services to Children in the Focus Population and take appropriate action if the Children are not receiving Home- and Community-Based Services, according to their needs as identified in their Plans of Care.	• Medicaid State Plan amendment • Capacity and utilization reports • Needs assessments (if any) • QSRs • Documentation of actions taken in response to children not receiving services	Federal approval and updated Medicaid Services Manual for new and expanded Medicaid services as well as updates to payment rates will be effective no later than January 1, 2027. This includes coverage of Family and Youth Peer Support and Respite Care. Specialty managed care plan will contract will include requirements around access standards. Compliance with access standards will be assessed by external quality review organization during readiness review (Fall 2026) and overall contract monitoring (2027 and beyond).
35.	These services will be offered in the home and community, Child- and Family- centered, individualized to the Child's and the Family's strengths and needs, of sufficient quality, and	• Service capacity and utilization reports • Needs assessments (if any) • State to provide policy and procedure documentation	Access standards will be outlined in the specialty managed care contract effective January 1, 2027.

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
	available and accessible statewide to all Children in the Focus Population in the necessary amount, location, and duration.		
36.	The goals of Home- and Community-Based Services will be to help Children in the Focus Population build the skills necessary to function successfully in the home, improve the Family's capacity to help the Children develop such skills, and to prevent crises and promote stability in the home.	• State to provide policy and procedure documentation • Service definitions	Medicaid Services Manual will be updated as needed no later than January 1, 2027.
37.	The State will establish and monitor compliance with timeliness standards for delivery of Home- and Community-Based Services. The timeliness standards will be established by the State after receiving and considering feedback from community partners, service providers, the United States, CMS, and the Independent Reviewer.	• State to provide policy and procedure documentation • State to provide documentation of meeting dates, agendas and meetings and documentation of receiving and considering written comments • Documentation of the engagement of community partners, providers, and DOJ • QSRs • Provider CQI/data reports • Documentation of monitoring	State will require timeliness benchmarks for services in the specialty managed care contract and Medicaid Services Manual, effective January 1, 2027. Performance monitoring on-going.
38.	The State will require providers of Home- and Community-Based Services to deliver services at times and locations mutually agreed upon by the provider and the Children in the Focus Population and their Families and during times of the day that meet the needs of the Children and their Families, such as after school and on weekends, as necessary and to the	• State to provide policy and procedure documentation • QSRs • Provider family satisfaction or family self-report survey. • Documentation of monitoring • Documentation of actions taken to ensure compliance	Requirements will be outlined in Specialty Managed Care contract and Medicaid Services Manual, effective January 1, 2027. Performance monitoring on-going.

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
	extent practicable. The State will monitor compliance with these requirements and take appropriate action to ensure compliance is met.		
39.	The State Medicaid program will cover transportation for the Children in the Focus Population and their Families to and from home for Home- and Community-Based Services that are provided outside the home setting.	• State to provide policy and procedure documentation • Medicaid claims data	Coverage for transportation is already in place and policy is outlined in the Medicaid Services Manual. Performance monitoring on-going.
40.	The State will create or revise Medicaid reimbursement methodologies and workforce development strategies to increase provider capacity for providing Home- and Community-Based Services so that the Focus Population can access these services.	• Medicaid state plan amendment • State to provide policy and procedure documentation • Medicaid and(/or other reports) documenting methodologies and workforce strategies • Data Reports • Interviews of providers	Federal approval for provider reimbursement changes is anticipated to be received in 2025.
41.	The State will provide Children in the Focus Population and their Families with accurate, timely, and accessible information regarding the available Home- and Community- Based Services in their communities.	• State to provide documentation and website of full behavioral health service array • Interviews with children and families	Website will be available by January 1, 2027.
42.	Children in the Focus Population and their Families will have the right to choose whether and when to receive any of the Home- and Community-Based Services and to choose among available providers enrolled in the State's Medicaid program.	• State to provide policy and procedure documentation	Requirements will be outlined in the Specialty Managed Care contract, effective January 1, 2027.

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43.	To the extent permitted under federal law for purposes of Medicaid reimbursement, the State will permit Families of Children in the Focus Population to access desired services in addition to the Home- and Community-Based Services described in this Agreement, such as services for IDD. If Children in the Focus Population receive services other than those listed in this Agreement, the Wraparound Facilitator will include those services in the Plan of Care and coordinate care where needed.	• State to provide policy and procedure documentation • QSRs • Provider CQI/data reports	Requirements will be outlined in the Specialty Managed Care contract, effective January 1, 2027.
44.	The State will establish policies for Home- and Community-Based Services that require providers to render services in a manner that is Trauma-Informed and culturally and linguistically appropriate; and provided in a manner that is safe, inclusive, and free from bias and discrimination. The State will monitor compliance with these requirements and take appropriate action to ensure compliance is met.	• State to provide policy and procedure documentation • Data reports • QSRs • Provider CQI/data reports • Documentation of monitoring • Documentation of actions taken to ensure compliance	Requirements outlined in Medicaid Services Manual and any necessary updates effective no later than January 1, 2027. Performance monitoring on-going.
45.	The State will continue to offer Specialized Foster Care pursuant to the requirements of Nevada Revised Statutes Chapter 424. Children in the Focus Population who are placed in Specialized Foster Homes (as defined by	• State to provide policy and procedure documentation • QSRs • Provider CQI reports	State is working with federal Centers for Medicare and Medicaid services on renewal of the Specialized Foster Care

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	NRS 424.018) will also have access to Home- and Community-Based Services appropriate to meet their needs. Wraparound Facilitators and/or Intensive Care Coordinators should involve Specialized Foster Care parents and agencies in the development of the Plan of Care and/or the coordination of services as appropriate.		benefit. Coverage is currently in effect. State policies permits youth to access specialized foster care services in addition to other services that are medically necessary. Medicaid Services Manual policy on Wraparound and Intensive Care Coordination will be finalized no later than January 1, 2027 and will outline protocols for involving for foster parents and foster care agencies in care planning, as appropriate.
46.	As a condition of payment in Medicaid, the State will require that all providers of Home- and Community-Based Services for Children in the Focus Population comply with state licensure and certification requirements and render services in a manner that is within their scope of practice under	• State to provide policy and procedure documentation describing requirements • State contracts with providers	Requirements outlined in Medicaid Services Manual.

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	state law. For providers without a licensing board or certification agency, the State will develop a state-approved certification process to ensure these providers are appropriately trained and qualified to render specific Home- and Community-Based Services to the Focus Population.		
	Mobile Crisis Response and Stabilization Services		
47.	The State will make a crisis hotline, Mobile Crisis Response Teams, and Mobile Crisis Response and Stabilization Services available to all Children under age 21 experiencing a behavioral health crisis regardless of Medicaid eligibility and regardless of whether they fall within the Focus Population. These services will be offered in alignment with the practices outlined in the Substance Abuse and Mental Health Services Administration (SAMHSA) guidance document titled National Guidelines for Child and Youth Behavioral Crisis Care (2022). If these guidelines are superseded at any point during the pendency of this Agreement, the parties will meet and confer to determine whether to make any changes to these services.	• State to provide policy and procedure documentation • State performance monitoring/data reports • QSRs • Provider CQI reports	The Department of Public and Behavioral Health (DPBH) is establishing 988 as the statewide resource for accessing mobile crisis services. This is currently in a pilot phase with full implementation by January 2027. DBPH will adopt regulations for the certification of mobile crisis services, which will be in effect by January 2027.
48.	The State will ensure that the crisis hotline is available throughout the state	• State to provide policy and procedure documentation • QSRs	The Department of Public and Behavioral Health

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	and staffed 24 hours per day, 7 days per week, including holidays. The State will establish quality assurance and oversight measures to ensure that calls to the hotline are answered live and not sent to a message system. The crisis hotline will have protocols and resources in place to quickly access translation services if there are no staff available with fluency in a caller's preferred language.	• Hotline CQI/data reports	(DPBH) is establishing 988 as the statewide resource for accessing mobile crisis services. This is currently in a pilot phase with full implementation by January 2027. DBPH will adopt regulations for the certification of mobile crisis services, which will be in effect by January 2027.
49.	The crisis hotline will:	• State to provide policy and procedure documentation • QSRs • Hotline CQI/data reports • Hotline family satisfaction survey data	The Department of Public and Behavioral Health (DPBH) is establishing 988 as the statewide resource for accessing mobile crisis services. This is currently in a pilot phase with full implementation by January 2027. DBPH will adopt regulations for the certification of mobile crisis services, which will be in effect by January 2027.
	a. Be staffed by clinical and paraprofessional behavioral health		

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	staff that have specialized training to meet the needs of Children, including Qualified Mental Health Professionals and paraprofessionals (which may include Family and Youth Peer Support);		
	b. Operate using the principle that crisis is defined by the Child and Family and is unique to that individual Child and Family;		
	c. Offer a response that is driven by the Child and/or Family rather than by criteria, lists, rubrics, or the discretion of hotline staff;		
	d. Use a developmentally appropriate, brief screening to gather presenting concerns, assess for safety and risk, and obtain basic demographic information;		
	e. Include the Child and/or Family in decision-making regarding mobile response services beginning at the initial contact;		
	f. Share, when available and when the Family consents, the Crisis Plan, and/or Plan of Care with the Mobile Crisis Response Teams working with the Child and Family;		
	g. Deploy a Mobile Crisis Response Team to the Family's location of choice;		

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	h. Assist with immediate stabilization efforts if needed before a Mobile Crisis Response Team arrives;		
	i. Help the caller identify and connect with needed local services when they do not want Mobile Crisis Response and Stabilization Services, to include warm handoffs and assistance in securing appointments with a local provider when possible; and		
	j. Receive warm hand offs from the 988 system for Children in crisis who enter through that hotline and are in need of Mobile Crisis Response and Stabilization Services. Hotline staff will assist in supporting the Child and Family and in connecting the Child and Family to Mobile Crisis Response and Stabilization Services.		
50.	After a Mobile Crisis Response Team is assigned, the Mobile Crisis services offered to the Child and Family will be comprised of two separate and distinct phases: response and stabilization.	• State to provide policy and procedure documentation • QSRs • Mobile Crisis Provider CQI/ data reports	State policy, including Medicaid Services Manual, have been updated to reflect these requirements.
	a. The initial crisis response phase supports a Child and Family through rapid engagement, assessment, and intervention to address the		

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	presenting crisis concerns and stressors, de-escalate the situation, assess for safety, and assist the Child and Family in creating and implementing a Crisis Plan that enables a Family to manage a crisis, move beyond the crisis, and avoid future crises. The initial response phase may last up to 72 hours.		
	b. The stabilization phase, which follows the initial crisis response phase, supports the Child and Family using in-home and community clinical interventions and/or with service planning and coordination, which establish connections for the Child and Family to community supports. Services in the stabilization phase will be driven by the Child's and Family's needs and may include, but are not limited to: ongoing crisis counseling; assistance in implementing safety and soothing plans; service planning; and providing resources and information on relevant services. Consistent with Child and Family needs, the stabilization phase may last up to 60 days.		
51.	Mobile Crisis Response Teams will respond at the Family's location of	• State to provide policy and procedure documentation • Mobile Crisis Provider CQI/ data reports	State policy, including Medicaid Services Manual,

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	choice within the time frames set forth in this Agreement:	• QSRs	have been updated to reflect these requirements.
	a. In Urban Clark (Cities of Las Vegas, North Las Vegas and Henderson) and Urban Washoe (Cities of Reno and Sparks) Counties and within any other urban area served by a Certified Community Behavioral Health Clinic (CCBHC), responses will be conducted face to face and in person, with an average response time within one hour for urgent responses.		
	b. Within areas of Clark and Washoe Counties not covered by subparagraph (a), and within CCBHC service areas in rural and frontier areas, responses will be conducted face to face and in person with an average response time within two hours for urgent responses. For urgent responses where remote travel distances make the 2-hour response time unachievable, telehealth may be used to provide crisis care to Children, but the ability to provide an in-person response must be available when it is necessary to assure safety.		

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
	c. In all areas of Nevada not covered by subparagraphs (a) or (b), responses may be conducted via telehealth or through a hybrid in-person/telehealth response model. Telehealth and hybrid responses in these locations will be initiated as soon as possible, but within one hour for urgent responses.		
52.	Consistent with Paragraph 49.h, the crisis hotline will assist with immediate stabilization. For all in-person responses, either the crisis hotline or a member of a Mobile Crisis Response Team will provide telehealth stabilization support as needed to Children and their Families in crisis during the Mobile Crisis Response interim travel time. The crisis hotline will connect Children in crisis with telehealth response in the event no Mobile Crisis Response Team in the service area is available.	• State to provide policy and procedure documentation • QSRs • Hotline CQI/data reports • Mobile Crisis Provider CQI/ data reports	The Department of Public and Behavioral Health (DPBH) is establishing 988 as the statewide resource for accessing mobile crisis services. This is currently in a pilot phase with full implementation by January 2027. DBPH will adopt regulations for the certification of mobile crisis services, which will be in effect by January 2027.
53.	For purposes of this Agreement, responses will be considered urgent when the Child in the Focus Population or their Family calls mobile crisis and identifies an immediate need for assistance.	• State to provide policy and procedure documentation • QSRs • Mobile Crisis Provider CQI/ data reports	State policy, including Medicaid Services Manual, have been updated to reflect these requirements. .

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
54.	The State will work to develop additional in-person crisis response capacity and to expand capacity of the CCBHC teams to provide in person responses within timeline standards in their assigned service areas.	• CCBHC CQI/data reports	Nevada Medicaid is implementing reforms to Medicaid reimbursement for Mobile Crisis services. These reforms will be in place by 2026. The Department of Public and Behavioral Health is also developing strategies to ensure statewide access to Mobile Crisis Services, with catchment area development expected to be completed by Spring 2026.
55.	Mobile Crisis Response Teams will consist of two individuals to include a Qualified Mental Health Professional and a second team member who may be another professional or a paraprofessional (which may include Family or Youth Peer Support).	• State to provide policy and procedure documentation • QSRs • Mobile Crisis Provider CQI/ data reports	State policy, including Medicaid Services Manual, have been updated to reflect these requirements.
56.	The State will identify standardized screening and assessment tools for use by Mobile Crisis Response Teams.	• State to provide policy and procedure documentation	State policy, including Medicaid Services Manual, will be updated to reflect these requirements by January 1, 2027.
57.	Mobile Crisis Response Teams will work collaboratively with a Child and Family	• QSRs • Mobile Crisis Provider CQI	State policy, including Medicaid Services Manual,

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	to create a Crisis Plan at the initial response. Crisis Plans should be reviewed at every contact and updated as needed. Crisis Plans should become part of a Child's Plan of Care.	• State to provide policy and procedure documentation	will be updated to reflect these requirements by January 1, 2027.
58.	Where the Child does not have a Child and Family Team, the Mobile Crisis Response Team will provide referrals and assist families with securing appointments for services as needed.	• State to provide policy and procedure documentation • QSRs • Mobile Crisis Provider CQI/referral data reports	State policy, including Medicaid Services Manual, will be updated to reflect these requirements by January 1, 2027.
59.	Mobile Crisis Response Teams will develop relationships and collaborative agreements with local emergency dispatch services and law enforcement to promote use of crisis hotline and Mobile Crisis Response Teams instead of law enforcement for Children in behavioral health crisis whenever possible. The State will develop and implement guidance for Mobile Crisis Response Teams to use in determining whether to call 911 or otherwise involve law enforcement.	• Mobile Crisis Provider CQI reports • State will provide documentation of the fully executed collaborative agreements between Mobile Crisis Providers and emergency dispatch and law enforcement in their territories • State to provide policy and procedure documentation	State policy, including Medicaid Services Manual, will be updated to reflect these requirements, including protocols for 911 referrals, by January 1, 2027.
60.	If a joint response between law enforcement and a Mobile Crisis Response Team is initiated, to the extent possible the Mobile Crisis Response Team will stay engaged and on the scene to provide behavioral health support and intervention.	• State to provide policy and procedure documentation • QSRs • Mobile Crisis Provider CQI reports	State policy, including Medicaid Services Manual, will be updated to reflect these requirements by January 1, 2027.

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
	Intensive In-Home Services		
61.	Intensive In-Home Services will be provided to Children in the Focus Population. These services are interventions built on the Child and Family's strengths and are aimed at improving the Child's functioning and the Family's ability to support the Child in the home. Consistent with Children's needs, Children will be able to access Intensive In-Home Services including Wraparound Facilitation, Individual Therapy, Family Therapy, Behavioral Support Services, Family Peer Support, Youth Peer Support, and Respite Care.	• State to provide policy and procedure documentation • QSRs • IIHS Provider CQI/data reports	Federal approval and updated Medicaid Services Manual for new and expanded Medicaid services as well as updates to payment rates will be effective no later than January 1, 2027. Services under development include Wraparound Facilitation and Respite Care. Individual therapy, family therapy, behavioral support services, family peer support, and youth peer support are all approved covered services in Nevada's Medicaid program.
62.	The State Medicaid Program will expand capacity for Children in the Focus Population to receive additional services including transportation, psychiatric services, and medication management, as appropriate.	• State will provide documentation of Medicaid State Plan amendment or waivers (if needed and applicable) to expand capacity for transportation, psychiatric services and medication management as needed • State to provide policy and procedure documentation of the expanded capacity	Medicaid coverage for these services are already in place. Monitoring of timeliness and access on-going.

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
		• QSRs and data reports	
63.	The State Medicaid Program will seek federal authority to cover additional services for Children in the Focus Population, including Supported Employment.	• State will provide documentation of requests for federal authority for Medicaid coverage of additional services, including Supportive Employment, including State Plan Amendments, Waivers, or other documentation •	Federal approval and updated Medicaid Services Manual for new and expanded Medicaid services as well as updates to payment rates will be effective no later than January 1, 2027. Supported employment will be required as a value-added service for the Specialty Managed Care Plan serving the focus population.
64.	The State will review evidence-based practices or models that may be appropriate to use when implementing Intensive In-Home Services. The State will indicate which models it considered and identify any it is adopting, including any plans for implementation and fidelity review, in its Implementation Plan (see Section X).	• State will provide documentation of models considered and models adopted and other appropriate documentation that may have contributed to the review and selection (e.g. meeting dates, agendas, and minutes from meetings considering which evidence-based practices)	State will establish Center of Excellence by 2027. Center of Excellence will review evidenced-based practices on an on-going basis and provide training and technical assistance to the Specialty Managed Care Plan and providers. Training and technical assistance is currently being provided by State Agencies (e.g. Department of Child and Family

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
			Services; Aging and Disability Services Division) and will continue on-going.
	Psychiatric Services and Medication Management		
65.	The State will maintain and enforce protocols to ensure Children in the Focus Population can access psychiatric evaluations and medication management when needed. The State will allow for telehealth provision of medication management where appropriate.	• State to provide policy and procedure documentation regarding med management, psychiatric evaluations and telehealth • QSRs • State will provide documentation of Medicaid State Plan amendment (if applicable) identifying use of telehealth	Medicaid coverage for these services are in place. Monitoring of timeliness and access on-going.
66.	Upon federal approval, the State will cover and make available mechanisms for peer-to-peer consultations between primary care providers and psychiatrists who have expertise in serving the Focus Population regarding medication management and other services where appropriate.	• State to provide policy and procedure documentation regarding peer-to-peer consultation between primary care providers and psychiatrists - Other documentation of peer-to-peer consultations as applicable (e.g., claims data, reports, etc.)	Medicaid coverage for these services are in place. Monitoring of timeliness and access on-going.

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Section 6: Diversion and Transition

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
67.	When a Child in the Focus Population with a Child and Family Team is referred for placement in a Residential Treatment Facility, the Wraparound Facilitator or Intensive Care Coordinator assigned to the Child's case will schedule a Child and Family Team meeting at the soonest opportunity that the Child, Family, and members of the Child and Family Team can meet to identify any potential changes to current or additional Home- and Community-Based Services and other supports the Child and Family need and that will prevent the residential placement. If additional Home- and Community-Based Services could prevent the residential placement, the Wraparound Facilitator or Intensive Care Coordinator will lead efforts to secure services and supports as soon as possible.	• State to provide policy and procedure documentation • QSRs • Provider CQI/data reports	Requirements will be outlined in Specialty Managed Care contract and/or Medicaid Services Manual effective January 1, 2027. Performance monitoring on-going.
68.	The State will establish protocols to ensure that when a Child in the Focus Population without an Intensive Care Coordinator or Child and Family Team is referred for placement in a Residential Treatment Facility, the State will connect the Child to Wraparound Facilitation, or Intensive Care	• State to provide policy and procedure documentation • QSRs • Provider CQI/data reports	Requirements will be outlined in Specialty Managed Care contract and/or Medicaid Services Manual effective January 1, 2027.

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
	Coordination if the Child and Family prefer. A Wraparound Facilitator or Intensive Care Coordinator will be assigned in a timely manner to support the Child and Family in creating a Child and Family Team. The Wraparound Facilitator or Intensive Care Coordinator will facilitate team meetings to identify and engage immediate supports and services to assist in stabilizing the Child in the Focus Population in the home when possible. The Wraparound Facilitator or Intensive Care Coordinator will lead efforts to secure services and supports as soon as possible.		Performance monitoring on-going.
69.	The State will establish a team of individuals with knowledge of the requirements of this Agreement that can serve as support and provide technical assistance to the Child and Family Teams for the Focus Population, and that will focus on engaging Home- and Community-Based Services as an alternative to Residential Treatment Facilities when clinically appropriate.	• Team's mission statement • List of team members • Interview of team members • State to provide policy and procedure documentation • Data reports • QSRs • Provider CQI reports	State will establish Center of Excellence by 2027. Center of Excellence will review evidenced-based practices on an on-going basis and provide training and technical assistance to the Specialty Managed Care Plan and providers.
70.	The State will provide assistance to any Child and Family Team for a Child in the Focus Population that requests support and any Child and Family Team serving a Child in the Focus Population who has experienced multiple Mobile Crisis Response and Stabilization Services or	• State to provide policy and procedure documentation • Documentation of assistance provided • Data reports • QSRs • Provider CQI reports	Requirements will be outlined in Specialty Managed Care contract and/or Medicaid Services Manual effective January 1, 2027.

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
	psychiatric hospitalizations over the past year.		Performance monitoring on-going.
71.	The State will conduct a regular review of each Child in the Focus Population who remains in a Residential Treatment Facility for longer than four months to identify barriers to discharge and recommend strategies to resolve barriers to the relevant Child and Family Teams.	• State to provide policy and procedure documentation • Documentation of reviews • Documentation of identification of barriers and recommendation of strategies • State performance monitoring/data reports • QSRs • Provider CQI/data reports	State will establish a review process and team to review individual cases by Summer 2026. Child and Family Team reviews will begin with launch of Specialty Managed Care Plan in January 2027.
72.	The State will revise the process for requests for authorization to Residential Treatment Facilities with the goal of ensuring Children in the Focus Population receive services in the most integrated setting appropriate to them. Determinations for appropriateness for Residential Treatment Facility placement will include consideration of the Clinical Assessment Tool, the Comprehensive Assessment, and the recommendation of the Child and Family Team. The State will review data and conduct random audits of Children in the Focus Population in Residential Treatment Facilities regularly to assess whether the process is preventing unnecessary placements, and the State will make additional revisions to the process if necessary.	• State to provide policy and procedure documentation • State performance monitoring/data reports • Documentation of results of audits • Documentation of any process revisions • QSRs • Provider CQI/data reports	Medicaid Services Manual, will be updated to reflect these requirements by January 1, 2027. Performance monitoring on-going.

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
73.	When a Child in the Focus Population is placed in a Residential Treatment Facility, their Wraparound Facilitator or Intensive Care Coordinator will serve as the liaison between the Child and Family Team and the Facility throughout the course of the treatment and will work with the Facility and the Child and Family Team to plan for discharge and transition of the Child to their home and community. The Child and Family Team or Intensive Care Coordinator will work with the Residential Treatment Facility to develop a transition Plan of Care that identifies strengths and needs of the Child, any Child-specific short- and long-term behavioral health goals, anticipated steps to achieve those goals and return the Child to the community, anticipated barriers to discharge and how they will be resolved, and a plan for securing Home- and Community-Based Services to ensure successful return to community. The Child and Family Team or Intensive Care Coordinator will review the transition Plan of Care at least every 30 days, to identify progress toward the stated goals and any barriers to discharge. To the extent necessary to effectuate this collaboration regarding the development and review of transition	• State to provide policy and procedure documentation • QSRs • Provider CQI reports	State policy, including Medicaid Services Manual, will be updated to reflect these requirements by January 1, 2027. Performance monitoring on-going.

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
	Plan of Care, the State will update its policies and, if needed, use its regulatory authority to develop and recommend changes within the Nevada Administrative Code.		
74.	The State will develop frequency standards for the administration of Clinical Assessment Tools for Children in the Focus Population in Residential Treatment Facilities to ensure the Clinical Assessment Tool is readministered to the Children within 90 days after admission, and thereafter every 45 days. The State will monitor to ensure that Children in the Focus Population are transitioned back to the community as soon as possible, and generally within 30 days, if the Clinical Assessment Tool indicates that the Child's functioning can be supported in a more integrated setting. Children in the Focus Population should transition to the community when they are appropriate for community-based services, regardless of whether the score on the Clinical Assessment Tool indicates that Residential Treatment may be appropriate.	• State to provide policy and procedure documentation • QSRs • Provider CQI/data reports • Documentation of monitoring	Requirements will be outlined in Specialty Managed Care contract and/or Medicaid Services Manual effective January 1, 2027. Performance monitoring on-going.
75.	The State will use its regulatory authority to develop and recommend regulation changes within the Nevada Administrative Code to ensure that	• State to provide updated regulatory documentation • State to provide policy and procedure documentation • QSRs • Provider CQI reports	State will update requirements as needed no later than January 1, 2027.

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
	discharge planning from Hospitals will include consultation with the Child in the Focus Population, their Family, and Wraparound Facilitator or Intensive Care Coordinator; and a warm handoff to Home- and Community-Based Services that the Child needs. The State will monitor and enforce compliance with these regulations.	• Documentation of monitoring and enforcing compliance	Performance monitoring on-going.

Section 7: Stakeholder Engagement

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
76.	The State will establish a multidisciplinary team within Department of Health and Human Services that will be responsible for training, engagement, and communication with providers, stakeholders, and Children in the Focus Population and their Families regarding the Agreement.	• List of Team members with agency affiliation • State to provide documentation of meeting dates, agendas and meetings minutes with providers, stakeholders, members of the focus population and their families	Team established and meeting bi-monthly. Training plan to be published in 2026.
77.	This team will seek and consider input from community partners, service providers, Children in the Focus Population and their Families, schools, and CMS on development, implementation, availability, and quality of Home- and Community-Based Services, including by conducting and publicizing public workshops and soliciting requests for comments on changes to rules and policies.	• State to provide documentation of meeting dates, agendas and meetings minutes and documentation of receiving and considering written comments • Documentation of meetings with providers, stakeholders, members of the focus population and their families, schools, and CMS	Community-led working group has been convened and meets monthly. Additional engagement with other community partners is on-going.
78.	On an ongoing basis, the State will update the relevant Commissions and Consortia regarding its implementation of this Agreement.	• State to provide documentation of meeting dates, agendas and meetings minutes with the relevant Commissions and Consortia	Regular meetings and updates on-going.

Section 8: Workforce and Provider Development

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
79.	The State will work with public and private stakeholders to develop a plan to address workforce shortages for Home- and Community-Based Services for Children in the Focus Population under this Agreement. The plan will be reviewed, analyzed, and updated to meet changes in the workforce over the course of the Agreement. The plan will address: (a) A proposed methodology for a baseline and ongoing measurement of the Focus Population's Home- and Community-Based Services workforce and the adequacy of the workforce to meet the needs of Children in the Focus Population; (b) Identification of staffing to support and coordinate the State's Home- and Community-Based Services workforce development efforts; and (c) Systematic recruitment and retention strategies for providers of Home- and Community-Based Services.	Plan documentation with the relevant components	Plan will be developed by Nevada Health Authority Office of Workforce Development by Summer 2026.
80.	The State, in partnership with Clark and Washoe Counties, will develop a plan to recruit, support, and retain foster parents to serve Children in the Focus Population in the custody of child welfare agencies across the State so that they may remain in and return to	State to provide a state and county Foster Care Recruitment and Retention Plan documentation	Department of Child and Family Services will publish plan by Fall 2026.

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	Family settings. The plan will be reviewed, analyzed, and updated to meet changes in the workforce over the course of the agreement. The plan will include: (a) Recruitment and retention strategies such as Child-specific recruitment, Family finding and other intensive kinship recruitment efforts, and incentives; (b) Identification of staffing to support and coordinate the State's foster parent recruitment and retainment efforts; and (c) Strategies to support and retain current foster parents to prevent unneeded placement disruptions where possible for Children in the Focus Population.		
81.	The State will develop provider capacity to address the particular behavioral health needs of Children in the Focus Population who are or have been in foster care and their families. The State will offer specialized training and supports to providers who work with families who have attained permanency through adoption, guardianship, or custody.	• Claims data • State's Training Plan and evidence of providing training (agendas, attendance, curriculum, and/or other similar records) • QSRs	Center of Excellence, in partnership with the Department of Child and Family Services, will develop and offer specialized training by 2027. State will report on training activities and outcomes.
82.	The State will make trainings available to providers of Home- and Community-Based Services to strengthen provider competency in provision of services to the Focus Population and will monitor	• State to provide documentation of Stakeholder Training Plan • Training data reports • QSRs • Documentation of monitoring	Center of Excellence, will develop and offer specialized training by 2027.

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
	providers of Home- and Community-Based Services to ensure staff providing these services are sufficiently trained. The State will also make trainings regarding Home- and Community-Based Services available to appropriate stakeholders, including State and county child welfare and juvenile justice workers, judges, prosecutors, public defenders, probation officers, law enforcement, and schools.	Description of training curriculum and training provider(s)	State will report on training activities and outcomes.

Section 9: Quality Assurance and Performance Improvement

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
	Data Collection		
83.	Within six months of the Effective Date, the State will provide baseline data to the United States and the Independent Reviewer. The baseline data will include all data elements agreed upon by the parties and that the State is able to report.	• Baseline Data report that includes all agreed upon data elements that the State is able to report	Baseline data report submitted on July 2, 2025.
84.	The State will develop collaborative agreements with county entities so that the counties share data regarding Focus Population Members in the juvenile justice system. The State will monitor compliance following establishment of these collaborative agreements.	• State to provide documentation of fully executed Data Sharing Agreements between pertinent state and county entities • QSRs • Documentation of monitoring	Collaborative agreements will be in effect no later than January 1, 2027. Compliance monitoring on-going.
85.	Beginning no later than six months after the State provides baseline data, the State will begin providing quarterly data to the United States and the Independent Reviewer.	• Quarterly Data reports	Initial quarterly data report will be published by January 2, 2026.
86.	At a minimum, the quarterly data will leverage all data sources available to the State to include data on the following areas:	• Quarterly Data reports	Quarterly data reports will be issued on-going. 2026 Report Schedule: January 2, 2026 April 1, 2026 July 1, 2026 October 1, 2026

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
	a. The number of Children in and the demographics of the Focus Population;	Captured in Medicaid eligibility and claims data housed in Nevada Medicaid Data Warehouse DDM. Data include age, gender, race/ethnicity, and county. Ongoing monthly updates; no external data sharing agreement required.	Currently reported in baseline and quarterly submissions.
	b. The Children in the Focus Population receiving Home- and Community-Based Services under this Agreement, broken down by County, including the types and amount of services they are receiving and the length of time of service utilization;	Available through Medicaid claims and prior authorization records. Data cover Medicaid-funded home and community-based services.	Data in active use for quarterly reporting. Refinement of county-level validation and cross-walk with provider data continues through 2026.
	c. For Children in the Focus Population, length of time from the completion of a Comprehensive Assessment that identifies the need for services to the initiation of Home and Community Based Services (excluding Mobile Crisis Response and Stabilization Services);	Nevada has not yet implemented a statewide Clinical Assessment Tool to identify when a child “receives a score on a Clinical Assessment Tool that indicates eligibility for hospitalization in a Hospital or a Residential Treatment Facility,” as described in the Settlement Agreement. This system is under development. Once implemented, data will reflect standardized eligibility indicators.	This is anticipated after the January 1st, 2027 launch of the Specialty Managed Care Plan.
	d. Data from Mobile Crisis Response Teams, broken down by County, including the number of calls to the Crisis Hotline, the number and location of Mobile Crisis Response Team responses, timelines of responses, outcomes following responses, and the repeated use of Mobile Crisis Response Teams;	Partial statewide reporting available through OOA for calls, response times, and outcomes.	Reporting will achieve full coverage by 2026 Q4 with some limitations due to data not being collected.

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
	e. Hospitalization of Children in the Focus Population, including use of emergency departments, admissions to and length of services at Hospitals for treatment of a Behavioral Health Disability, and repeated hospitalization;	Captured in Medicaid claims using ICD-10 codes. Includes admissions, length of stay, and repeat use. No external DSA required.	Fully implemented; ongoing quarterly reporting.
	f. Placement of Children in the Focus Population in Residential Treatment Facilities, number of Children in the Focus Population who sought authorization for Residential Treatment of Facilities, the number of Children in the Focus Population authorized for Residential Treatment Facilities, the number of Children in the Focus Population admitted to Residential Treatment Facilities and their length of stay, and the number of Children in the Focus Population remaining in Residential Treatment Facilities more than 30 days after no longer medically necessary;	Documented through Gainwell prior authorization data and Medicaid claims. Data currently unavailable for the number of Children in the Focus Population remaining in PRTF more than 30 days after no longer medically necessary".	Included in quarterly data reporting. Coordination with DCFS for validation of non-Medicaid placements ongoing.
	g. Involvement of Children in the Focus Population in the child welfare system, including the number of Children in the Focus Population in child welfare emergency shelter care; length of stay in the emergency shelter care; the number of Children in the Focus	Data reside in DCFS UNITY system.	Included in baseline data reporting and in future quarterly data reporting.

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
	Population in foster care who are hospitalized for Behavioral Health Disabilities; and the number of Focus Population Members in foster care who are placed in Residential Treatment Facilities;		
	h. Involvement of Children in the Focus Population in State Youth Parole Bureau facilities; and	Data maintained by DCFS	Currently reported in baseline and quarterly submissions.
	i. Involvement of Children in the Focus Population in the county juvenile justice systems, to the extent data are available to the State pursuant to the collaborative agreements with county entities set forth in this section.	County-level systems hold data; additional MOUs/DSAs to be executed with counties statewide.	Phased integration 2026 - 2027.
87	Within one year of the Effective Date, the State will develop a public-facing data dashboard on its website leveraging all data sources available to the State. The dashboard will include, at a minimum, the number of Children in the Focus Population placed in Residential Treatment Facilities on the last day of each month, the number of Children in the Focus Population placed in Residential Treatment Facilities out-of-state on the last day of each month, and the number of Children in the Focus Population who have been Hospitalized for a Behavioral Health Disability in the last month. The data dashboard will be	State to provide documentation and public facing website making available pertinent focus population data and data reports; dashboard will be updated at least quarterly	Public dashboard will be published no later than January 2, 2026, and updated at least quarterly.

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	updated at least quarterly but may be updated more often.		
	Data Analysis		
88.	Within six months of the Effective Date, the State will convene a Quality Meeting that will be attended by personnel from all State agencies and entities responsible for implementing the Agreement. Quality Meetings will occur no less than quarterly to review data; analyze progress toward compliance with the Agreement; and plan, implement, and assess any needed responsive action plans to improve outcomes using a Continuous Quality Improvement framework.	• State to provide documentation of Quality Meetings dates, agendas, and meeting materials	Initial quality meetings began January 2025 via the interagency council and continue bimonthly.
89.		• State to provide policy and procedure documentation • QSRs • Provider CQI/data reports and other process documentation	Quality plan will be developed no later than January 2, 2026.
90.	Within one year of the Effective Date of this Agreement, the State will conduct a systemic assessment of the Children placed in Residential Treatment Facilities, identify the services commonly needed to return to their communities, and develop a plan to address any barriers to accessing those services.	• State to provide RTF policy and procedure documentation • State to develop and provide documentation of service system needs assessment • State to provide a Service System Enhancement Plan (including plan to address any barriers)	Assessment will be completed no later than January 2, 2026.
91.	No later than eighteen months after the Effective Date of this Agreement, the State will begin producing annual	• QAPI reports • Status updates	Initial report will be published no later than

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
	Quality Assurance and Performance Improvement Reports, which will include analysis of the available data, responsive action plans to address issues identified through that analysis, and information about the Quality Meetings. These Reports will measure the degree to which Children in the Focus Population are being diverted from and transitioned out of residential treatment. The Reports will also assess whether the services delivered to under this Agreement are available in a timely manner and accessible statewide to Children in the Focus Population, individualized to the Children Focus Population and their Family's strengths and needs, and sufficient in quality, intensity, and duration to meet the Child's needs. The Reports will identify the service needs that posed barriers to diversion or caused delays to transition and provide an estimate of the need for each service. These Reports will not contain any Child's personally identifiable information. At six-month intervals between the annual Quality Assurance and Performance Improvement Reports, the State will produce status updates regarding any major issues identified by the Parties.		July 2, 2026, and annually on-going.

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
92.	The State will post Quality Assurance and Performance Improvement Reports to the State's website within 30 days of finalization.	QAPI Status Update reports posted on website State will provide notification to the IR when QAPI reports to website	Initial report will be available on the State's website no later than August 1, 2026.
93.	The State will ensure that its agencies and entities collaborate to collect, share, and analyze the necessary data to comply with this Agreement's requirements.	State to provide documentation of fully executed Data Sharing Agreements between pertinent state and county entities	Data agreements will be finalized by Spring 2026.
94.	Within six months of the Effective Date, the State will begin reporting to the United States and the Independent Reviewer, on a monthly basis, any neglect or abuse reports and critical incidents relating to Children in the Focus Population associated with providing Home- and Community-Based Services required by this Agreement or with Hospital or Residential Treatment Facility services provided to the Focus Population. The State will consider these reports in planning for responsive actions to improve outcomes for Children in the Focus Population.	State to provide monthly data reports that include abuse and neglect and critical incidents of focus population	State will issue initial report by August 2025 reflecting data for initial six months. On-going reporting will occur monthly.
	Quality Service Review Process		
95.	"Quality Service Reviews" (QSRs) are in-depth assessments of services provided to specific Children in the Focus Population. QSRs will evaluate if the Child and Family needs are being identified, if goals are strength based and Child and Family driven, if the	N/A (explanation of requirement)	N/A

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	Child's needs are being met in the most integrated setting appropriate to their needs, and if services provided are sufficient to enable the Child to remain with or return to their Family, home and community, if appropriate. For Children in Hospitals and Residential Treatment Facilities, these reviews will evaluate any barriers to returning to home and community settings.		
96.	Beginning eighteen months after the Effective Date and at least annually thereafter, the Independent Reviewer will conduct QSRs of a random sample of Children in the Focus Population in Hospitals, Residential Treatment Facilities, and the community. The sample will include a sufficient number of Children receiving Home- and Community-Based Services to enable the Independent Reviewer to draw systemic conclusions about each service. The sample will also include Children assessed using the procedures outlined in the Screening and Assessment section who are not receiving services described in the Home and Community Based services section to enable the Independent Reviewer to draw reliable conclusions about whether the screening and assessment process is successfully	• State participation in the QSR	State will participate in QSR on-going as directed by independent reviewer.

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
	identifying the Children who require the services included in this Agreement.		
97.	When the Independent Reviewer and the State determine it is appropriate, the Independent Reviewer will begin training the State officials who will be responsible for the QSRs. These State officials will shadow the Independent Reviewer while the Independent Reviewer conducts the QSRs. Under the direction of the Independent Reviewer, the State officials will train additional State representatives to conduct the QSRs. After the Independent Reviewer and the State agree that it is appropriate, the State representatives will conduct the QSRs using the agreed upon QSR process. The Independent Reviewer will review and validate QSR data and analysis conducted by the State representatives.	• State officials QSR training • State to provide policy and procedure documentation • QSR reports	State will participate in QSR on-going as directed by independent reviewer.
98.	At a minimum, the QSRs will collect information through:	• QSR procedures and reports	State will participate in QSR on-going as directed by independent reviewer.
	a. Interviews with Children, Families, their Wraparound Facilitators/Intensive Care Coordinators, and, where appropriate, child welfare case workers, probation or parole officers, Home- and Community-Based Services providers, school		

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	staff members, and Hospital or Residential Treatment Facility staff, and		
	b. Analysis of Plans of Care, Crisis Plans, transition plans, treatment records, and outcome data related to the Children whose records are reviewed.		
99.	If during the course of the QSR process a Child is identified as subject to an immediate safety risk, the individual conducting the QSR will inform the State of the immediate risk and the State will take appropriate action to ensure the Child's safety.	• QSRs	State will participate in QSR on-going as directed by independent reviewer.
100.	Each year, the results of the QSR will be described in writing. The QSR analysis and description will not contain any Child's personally identifiable information. The State and the United States will work with the Independent Reviewer to create an analysis format. Until the State representatives conduct the QSR in accordance with Paragraph 97, the Independent Reviewer will conduct the annual QSR analysis and include it in one of the Independent Reviewer's semiannual Compliance Reports. A draft of QSR analysis and description will be provided to the State and the United States for comment at least 30 days prior to its finalization. The	• QSR Annual Reports • State to provide policy and procedure documentation	State will provide feedback on the QSR within 30-days of receipt.

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	State and the United States will provide comments and/or corrections, if any, to the Independent Reviewer within 15 days of receipt of the draft. The Independent Reviewer will consider the responses of the State and the United States and make appropriate changes, if any, before finalizing the QSR summary for inclusion in the Compliance Report. The Independent Reviewer will provide a response to the State and the United States explaining his or her reasons for not incorporating any comments or requests.		
101.	When State representatives take responsibility for conducting the QSR, the State representatives will complete the analysis using the same approach as the Independent Reviewer. The State will publish its annual QSR analysis in its annual report, along with a summary written by the Independent Reviewer of his or her review of the State's QSR, including a report of the review and validation determination made by the Independent Reviewer. A draft of the summary will be provided to the State and the United States for comment at least 30 days prior to its issuance. The State and the United States will provide comments and/or corrections, if any, to the Independent Reviewer within 15	• State's QSR analysis	State will take responsibility for the QSR process upon completion of Independent Review process.

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	days of receipt of the draft summary. The Independent Reviewer will consider the responses of the State and the United States and make appropriate changes, if any, before issuing the final summary for inclusion in the QSR report. The Independent Reviewer will provide a response to the State and the United States explaining his or her reasons for not incorporating any comments or requests into the final summary.		
102. N	The State will use data from the QSRs to identify strengths and areas for improvement at the provider, region, and system-wide levels. The State will identify responsive steps to improve services in response to the analysis of quality sampling review data in its Quality Assurance and Performance Improvement Reports.	State to provide documentation of a state, region and provider Performance Improvement Plan including documentation of identification of strengths and areas for improvement and documentation of responsive steps.	Provider performance improvement plan will be developed following initial QSR and updated annually.

Section 10: Implementation

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
103.	Within five years, the State will develop and ensure the substantial availability of the services required under this Agreement and reduce its dependence on Hospitals and Residential Treatment Facilities for the Focus Population in accordance with Title II of the ADA. The State will develop a specific Implementation Plan to fulfill the obligations of this Agreement.	• State to provide documentation of a “look-back” acknowledging community-based service enhancements • Data showing available services • State to provide a Congregate Care reduction report. • State to provide Implementation Plan	Report will be published no later than January 2, 2030.
104.	Within 30 days of the Effective Date, the State will designate an Agreement Coordinator to coordinate compliance with this Agreement and to serve as a point of contact for the Parties and the Independent Reviewer.	• State to provide documentation of the identified Agreement Coordinator and role and responsibilities	The State Medicaid Director has been identified as the Agreement Coordinator.
105.	The State will develop its first annual Implementation Plan and provide it to the United States and Independent Reviewer within six months of the Effective Date. The Implementation Plan will be designed to bring the State into compliance with the ADA and all requirements of this Agreement within five years. At a minimum, the Implementation Plan will include timelines and steps it will take to:	• State to provide Annual Implementation Plan	Implementation plan submitted for review as of August 1, 2025.
	a. Ensure statewide access for the Focus Population to Home and		

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
	Community- Based Services described in this Agreement;		
	b. Create and implement a plan to address workforce shortages and provider development relating to services in this Agreement;		
	c. Develop a data collection and reporting plan;		
	d. Develop quality assurance and performance improvement measures; and		
	e. Achieve reduction of Children in the Focus Population being unnecessarily placed in Hospitals and Residential Treatment Facilities, including setting goals and benchmarks for the total reduction of Focus Population members in these settings in accordance with Title II of the ADA.		
106.	The United States and the Independent Reviewer will provide comments regarding the Implementation Plan within 30 days of receipt. The State will consider all comments and, if necessary, timely revise its Implementation Plan to address comments from the United States and the Independent Reviewer; the Parties and the Independent Reviewer will meet and consult as necessary. After the State has revised the Implementation Plan, it will invite	• State to provide documentation of public comments and feedback received	State will review feedback and update and will issue plan for public comment no later than November 1, 2025.

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	and consider public comment and feedback, including from the stakeholders described in Section VII.		
107.	The Parties and the Independent Reviewer will meet and consult at least monthly during the first year of this Agreement and at least quarterly thereafter.	• Monthly meetings with IR in first year; at least quarterly thereafter	Regular meetings on-going.
108.	Annually, the State will supplement the initial Implementation Plan to update and provide additional detail regarding remaining implementation activities. The United States and the Independent Reviewer will provide comments regarding the Implementation Plan supplements within 30 days of receipt. The State will consider all comments and, if necessary, timely revise its Implementation Plan and supplements. The State will also address any areas of non-compliance or other recommendations identified by the Independent Reviewer in its supplemental Implementation Plans.	• State to provide Supplement Implementation Plan	Supplemental Implementation Plan will be updated at least annually.
109.	The State will make the Implementation Plan publicly available, including by posting the initial Implementation Plan, and each supplemental Implementation Plan, on the State's website.	• State shall notify IR of official posting	Implementation plan and supplemental plans will be posted on State website.
110.	To implement the requirements of this Agreement, the State will seek all necessary funding and authority to	• State to provide documentation of executed contract for Specialty Managed Care Plan	State will procure a Specialty Managed Care

<u>Settlement Item</u>	<u>Agreement Requirement</u>	<u>Evidence for Compliance (Review Plan)</u>	<u>Implementation Timeline</u>
	establish a Specialty Managed Care Plan that will be responsible for service delivery management and data system development for the Focus Population in Medicaid. In addition, the State may establish a stakeholder advisory committee to advise the State with its development of the new Specialty Managed Care Plan, including contract requirements.	• State to provide documentation of Stakeholder Advisory Committee including names, dates, meeting agenda and minutes, if applicable	Plan that will be effective January 1, 2027. Design of the plan will be overseen by the established working group.
111.	The State will submit any proposed policy or regulatory changes needed to effectuate this Agreement, including changes to its Medicaid program, to the United States and the Independent Reviewer before implementation. The United States and the Independent Reviewer will respond to the State with any comments within 30 days of receiving the proposed changes.	• State will provide documentation (as needed) to proposed policy and regulatory changes that are needed to effectuate this Agreement.	State will seek federal approval on-going as required to implement the agreement.