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Children's Behavioral Health Transformation:
Medicaid Benefits Working Group

Nevada Medicaid

August 14, 2025

NEVADA HEALTH AUTHORITY

Division Administrator Ann Jensen

Agenda

1. Introductions & Roll Call	4:30 – 4:35 PM
2. Follow-ups from July Working Group	4:35 – 4:45 PM
3. Specialty Managed Care Plan Feedback	4:45 – 4:55 PM
4. Care Coordination	4:55 – 5:20 PM
5. Wrap-up	5:20 – 5:25 PM
6. Public Comment	5:25 – 5:30 PM
7. Adjourn	5:30 PM

Roll Call

Representatives: *please add your name and affiliation/organization to the Teams chat to confirm your attendance! If you are joining by phone, please verbally confirm your attendance.*

Follow-ups from the July CBHT Working Group

Help us select a name for our Specialty Managed Care Plan!

The following names were submitted by Working Group representatives & attendees, and have been narrowed to a top three:

Nevada W.I.S.H. –
Wraparound Intensive Supports for Healing

Silver State Kids Plan –
Connecting Nevada's kids to the care they deserve. At home, in school, and beyond

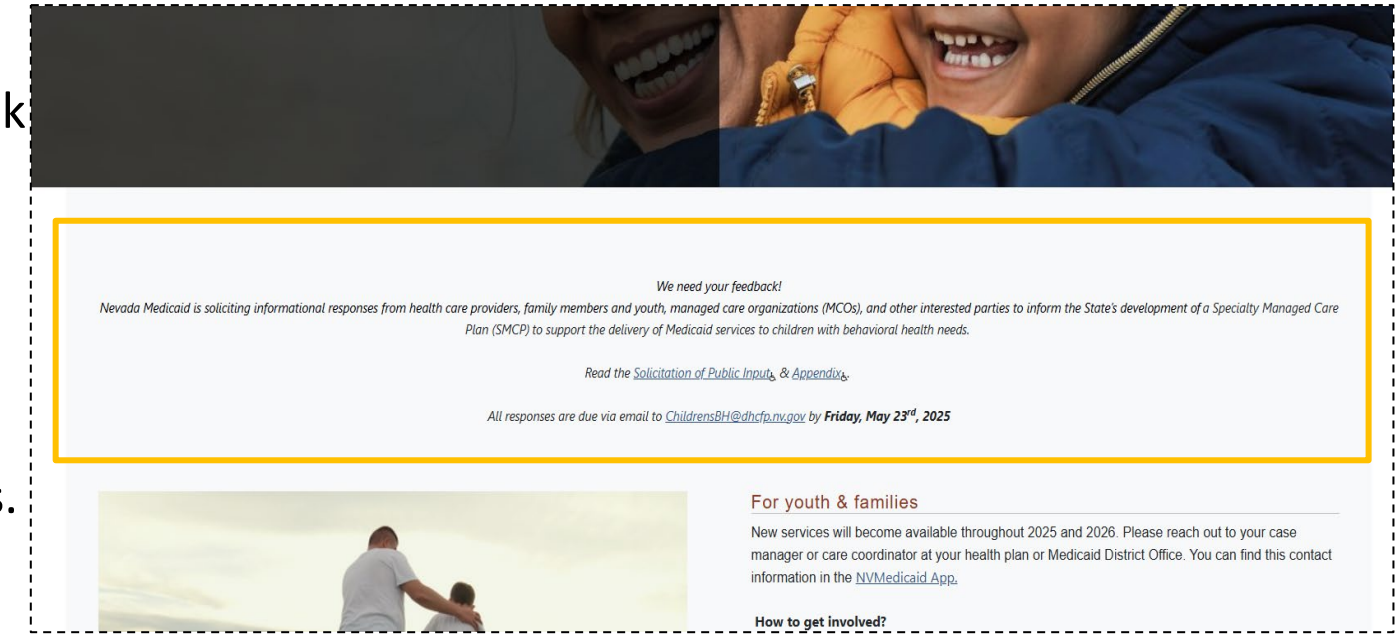
Pathways Plan –
Focus on creating pathways to support

Instructions: Please review and vote on your top choice **HERE** by **Friday, August 29th.** We will select the final name based on majority preference and alignment with our guiding principles.

Public Feedback on the Specialty Plan

Request for Public Feedback process:

- In May 2025, we issued a request for feedback to inform specialty managed care plan design for children/youth with behavioral health needs.
- In particular, we sought input on the focus areas of case management, care approach, benefits, provider network, cross-system collaboration, and contract design safeguards.



We received **26 submissions** from the following groups:

- 6 MCOs | 3 Health Systems/Academic Institutions | 2 County Agencies
- 5 Advocacy/Nonprofits | 4 Family/Youth | 3 Provider Groups | 2 State Staff

What We Heard: Feedback on the Specialty Managed Care Plan

Key Themes :

- **Strong Support for Wraparound and Peer Support**: Emphasis on whole-child models, lived experience, and locally designed care coordination services.
- **Regional Variation in Preferences**: Focus on flexibility and local design to best serve youth across all areas of the state.
- **Provider Network Concerns**: Highlighted challenges around workforce, reimbursement, and training pipelines.
- **Public Accountability**: Broad support for dashboards, quality measures, and transparency; range of input on how performance targets should be set.
- **Cross-Sector Coordination**: Strong desire for shared care planning and integrated systems, with differences in preferences on platform design for data management.

Quotes from Feedback Submitted:

"Wraparound must be family-driven and connected to the community. Families should not have to navigate the system alone."

- Behavioral Health Provider Organization

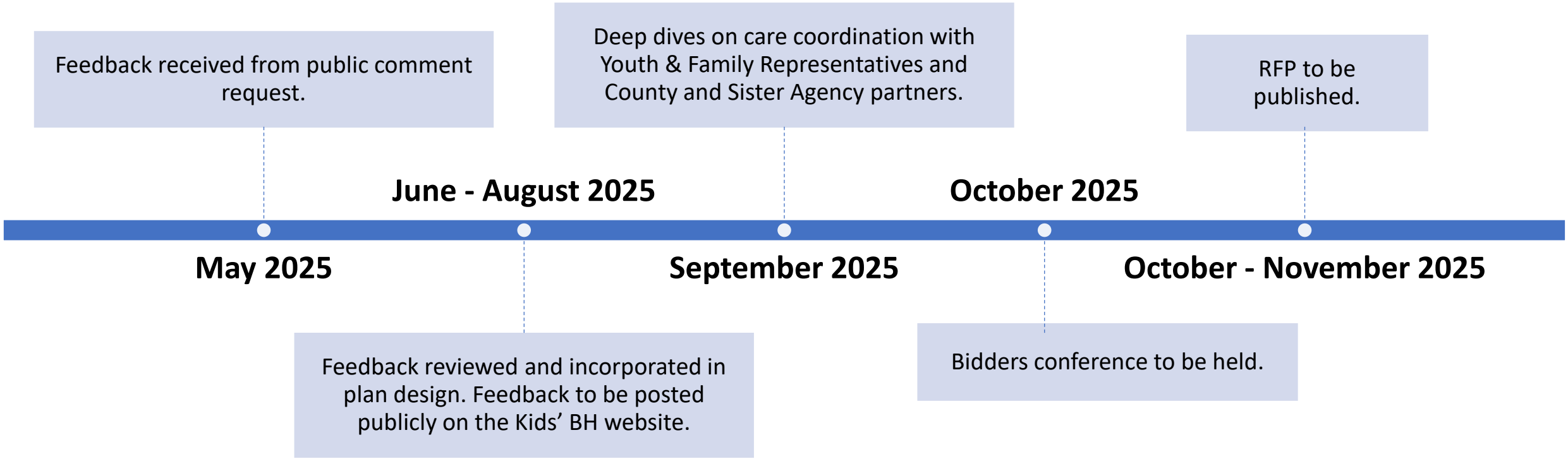
"We need a model that works in the rural frontier. Don't assume Clark and Washoe represent everyone."

- County Partner

"Care teams must include peer support as a core service. Lived experience matters."

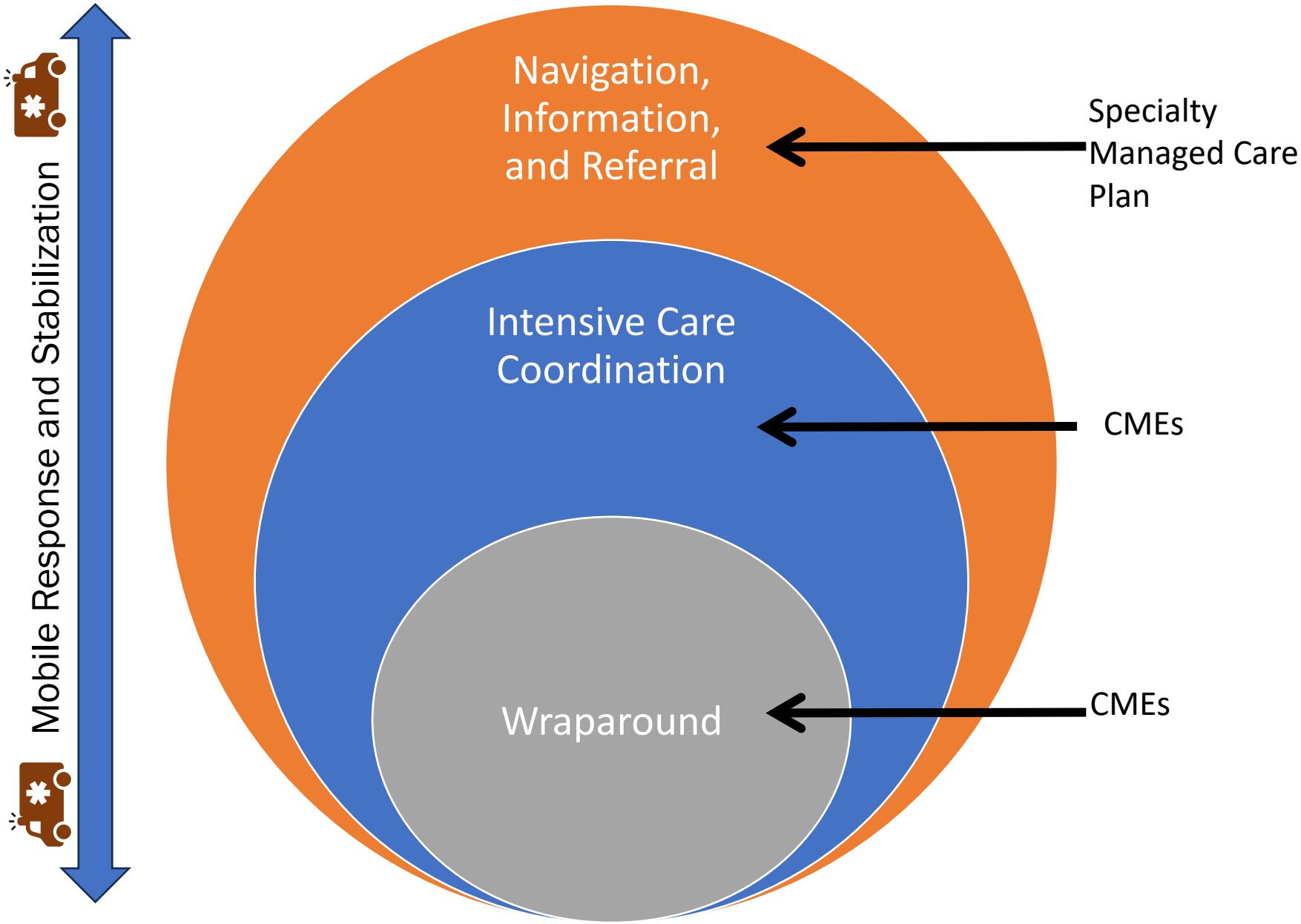
- Youth Advocacy Group

A reminder on where we're headed.



Presentation & Discussion:
Care Coordination

What is the continuum of care management?



Why is effective care management needed?

- Youth with complex behavioral health challenges have multiple & overlapping areas of need
- Families often have unmet basic needs
- Traditional services do not attend to health, mental health, substance use, & basic needs holistically
- Prioritization of what to work on is hard to figure out

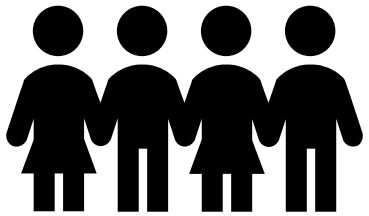
- Child-serving systems are complex & difficult to navigate, & families often do not know how or where to access services.
- Families & youth often feel that the system is not working for them
- Limited engagement leads to treatment dropouts & missed opportunities

- Systems do not work together well for individual families unless there is a way to bring them together
- Youth get passed from one system to another as problems get worse
- Families relinquish custody to get help
- Youth are placed out of home

Who is care coordination intended to serve?

"**'Child and Family Team**' is a group of individuals, chosen with the Family of a Child in the Focus Population and connected to them through **natural, community, and formal support relationships**, that develops and implements the Plan of Care. The Child and Family Team is led by the Wraparound Facilitator. The Child and Family Team includes the Child and Family, a Wraparound Facilitator, **relevant service providers, educators, and, where desired by the Child or Family, any additional formal or natural supports**. The Child in the Focus Population and Family are active members of the Child and Family Team and partners in service planning and coordination, including in the identification of resources that could help the Child live with Family, have success in school, enhance community living skills and resiliency, and develop the skills to function independently upon reaching adulthood."

(Section II, Paragraph C)



What will care coordination look like in the Specialty Plan?

How do families access care coordination services?

- All children/families in the Focus Population must be offered Wraparound Facilitation
- If a family declines Wraparound Facilitation, they must be offered Intensive Care Coordination
    - State must track reasons for declining wraparound facilitation
- State must establish timeliness standards for this process with community feedback.

*What's **not** already set by the Settlement Agreement and will be designed by this Working Group: how care coordination is **experienced** by families – what makes it helpful, trustworthy, responsive, or inclusive.*

Who provides care coordination services?

- The specialty managed care plan will be required to contract with **Care Management Entities (CMEs),** which will be regionally based community organizations and provider groups.
- CMEs will provide Intensive Care Coordination and Wraparound Facilitation.
- The specialty managed care plan will be responsible for care coordination for youth who do not qualify for or decline care coordination services via the CMEs. They will also support coordination of medical services.
- Both the CMEs and the managed care plan will be required to coordinate with any other providers who have any responsibility for helping to manage a youth's care (e.g., disability waiver services, foster care).

How is this defined in the settlement agreement?

"'**Intensive Care Coordination**' is a service that coordinates all formal and informal supports and services delivered to a Child in the Focus Population. Intensive Care Coordination includes development of the Plan of Care and referral and linkage to and coordination with appropriate services, based on the Comprehensive Assessment and the Plan of Care."

(Section II, Paragraph O)

"**Intensive Care Coordinator**' is an individual who is trained to work in a strengths-based manner to develop a Plan of Care for a Child in the Focus Population, in coordination with the Child and Family, and who supports referral, linkage and coordination between identified services."
(Section II, Paragraph P)

"'**Wraparound Facilitation**' is a benefit that facilitates comprehensive care planning and coordination for a Child in the Focus Population. The benefit is based on a structured approach to service planning and coordination and includes the following service components: (1) meetings with Child and Family Teams for assessing needs in support of the service delivery process; (2) state and local provider and agency collaboration to develop the supports to ensure the Child's success in the home and community; and (3) strengths-based planning and facilitation to assist the Child and Family Team with the Child's care."

(Section II, Paragraph CC)

"'**Wraparound Facilitator**' is an individual who is certified to facilitate the high-intensity, high-frequency Wraparound intervention to Families and Children in the Focus Population with complex needs, who guides team development and oversees the process and tasks of the team in order to develop and implement a comprehensive Plan of Care to ensure that Children in the Focus Population are able to remain In their homes, schools and communities."
(Section II, Paragraph DD)

What do these services mean in practice?

What is Wraparound

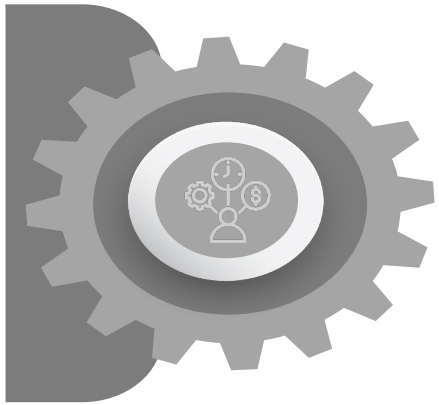
Wraparound is an ecologically based care coordination approach to ***care planning*** designed to ***support youth with complex needs and their families***.

What is Care Coordination

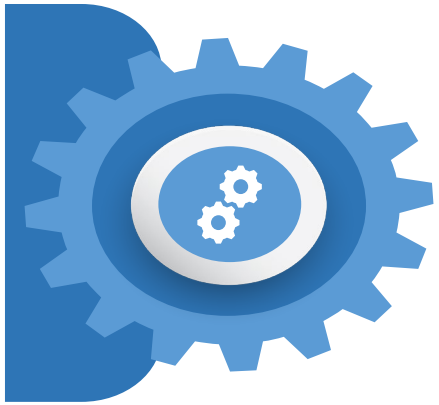
Care coordination, managed by a **dedicated care coordinator,** is the **deliberate** organization of services and supports in partnership with the child, youth, young adult and/or family to ensure **continuity of care** across settings and **facilitate** appropriate access and delivery of needed social, behavioral, and somatic health care. Organizing care involves **ongoing engagement, review, and adjustment** of relevant providers, natural supports, and other resources to successfully **align needs with services and supports**.

Why do we need “tiers” of care coordination?

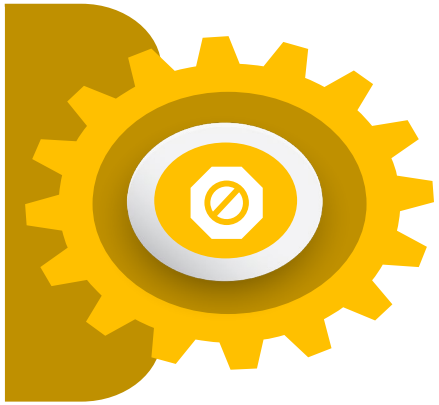
Efficient Allocation of Resources



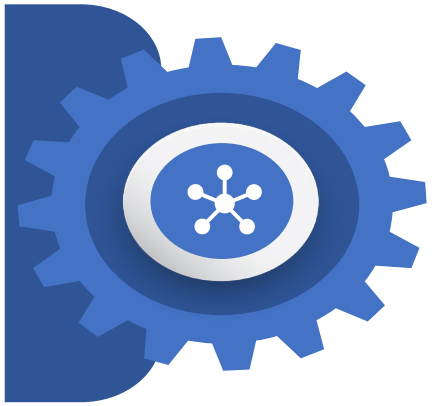
Customization of Services and Supports



Prevention of Crisis Escalation



Support for Systematic, Coordinated Care



Improved Outcomes and Accountability

Sustainable and Scalable

The elements and components of Wraparound are all necessary and must be sustained and maintained.

01

Fidelity and Quality

Critical elements are designed to build on one another and work together

02

Consistency

Different definitions or operationalization of the practice model impact families' experiences of Wraparound

03

Staffing Ratios

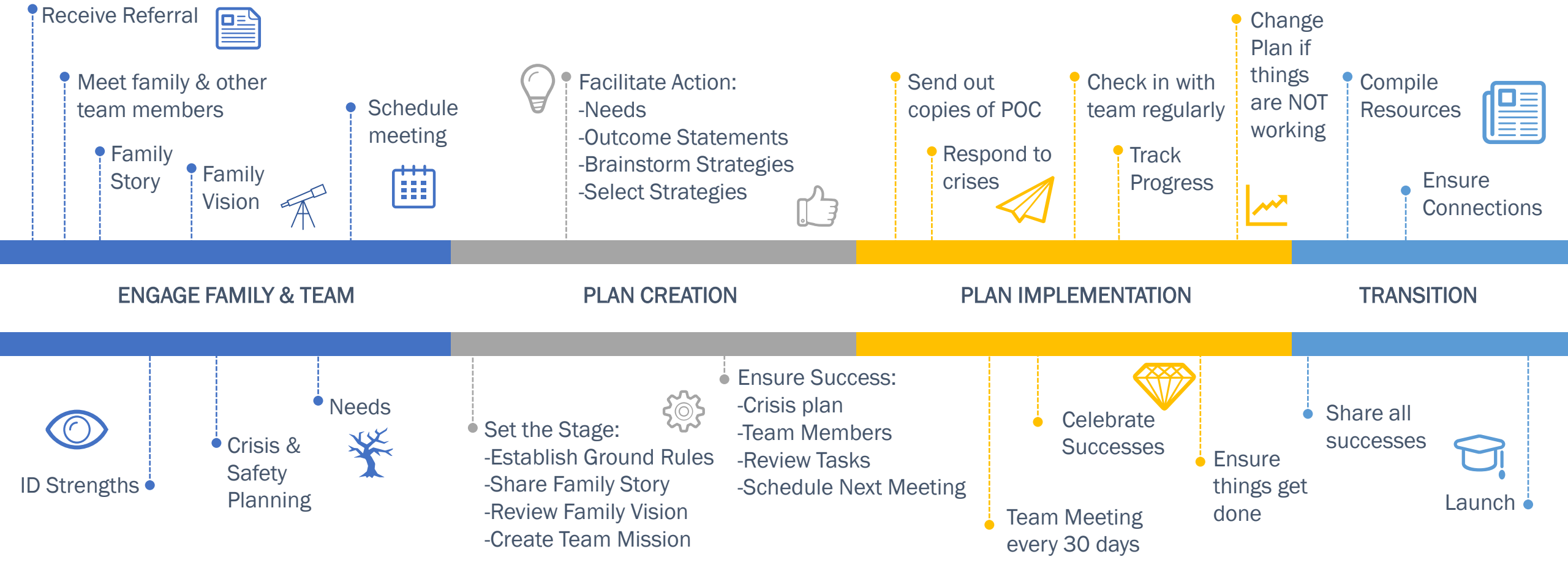
Limits: 1:8-12

04

Workforce

Varying expectations impact skill development and staff retention

What does Wraparound actually look like?



Why is Intensive Care Coordination necessary?

Prevents escalation of needs by addressing moderate concerns early

Offers cost-effective services tailored to those who don't need intensive care

Supports a larger population without overwhelming high-intensity programs

Promotes stability and continuity of care for children who need ongoing, structured support.

Enhances system efficiency and prevents unnecessary use of expensive resources.

How are Youth and Family voices reflected in the design of our care coordination model?

Purpose of the "Youth and Family Summit":

- Co-design care coordination for Nevada's new Specialty Managed Care Plan (SMCP) for children' youth with behavioral health needs.
- Ensure family and youth lived experience drives program design and is incorporated in our Specialty Plan procurement process.

When & How:

- **Date**: September 16, 2025
- **Format**: Virtual (Teams) | 3 hours | Structured facilitations, visuals, and live note capture
- **Audience**: Family & Youth representatives and Working Group representatives with lived experience as a youth or family member navigating Nevada's behavioral health system.

What are the objectives of our time together?

✓Identify key priorities and pain points in current systems.

✓Define values and principles to guide plan development.

✓Shape expectations for care team roles, communication, and accountability.

✓Elevate diverse voices representing our Nevada families to influence SMCP care coordination design.

How Family & Youth Representatives Can Prepare for Pre-Summit Engagement

Next Steps:

- **September 6th:** Pre-feedback from attendees is due.
  - Details on this process will be shared via email with all attendees. These will come in the form of a short reflection form (written or verbal) shared via email or in a 1:1 conversation with co-chair or youth/family leads.
  - The goal is to allow attendees to shape the agenda and discussion prompts, and to ensure all perspectives are represented even if you don't speak live.
- **September 16th:** Youth & family leads will co-facilitate the summit and bring feedback from external youth & family focus group discussions.
- Results will be shared at the **October CBHT Working Group meeting** and on our website.

Key Reflection Questions:

- *What has helped you or your family feel supported when navigating services?*
- *What gets in the way of good care coordination?*
- *Who should be on a care team, and how should they communicate?*
- *What values should guide Nevada's care coordination program?*

Care Coordination **DISCUSSION**

The following questions are provided as prompts to help think about different aspects of care coordination. Please reflect on the ones that resonate most with your experience or perspective.

1. **What has helped you or your family feel supported when navigating services?**
2. **What gets in the way of good care coordination?**
3. **Who should be on a care team, and how should they communicate?**
4. **What values should guide Nevada's care coordination program?**

Wrap-up

Meeting Takeaways

Next Steps:

- *All Working Group members:*
  - Reflect on specialty plan feedback and care coordination principles; feedback is welcome via email at ChildrensBH@nvha.nv.gov
  - Submit your vote for the specialty managed care plan name HERE
- *Summit attendees:* Prepare for the Youth & Family Summit based on information shared through forthcoming announcements.

Key Takeaways:

✓Final plan design must reflect both settlement compliance and lived experience

✓Input is essential to building a plan that works for Nevada families

Please join us at our next meeting on **Thursday, October 9th from 4:30-5:30 pm.**
(As a reminder, the Youth & Family Summit is taking the place of our September meeting!)

Public Comment Period

Time limit: 3 minutes

Thank you for your time!

Feedback or questions?
Reach out to us at childrensbh@nvha.nv.gov.