Section I - Program Description

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

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

THE NEED FOR TRANSFORMING OUR SYSTEM

The Nevada Department of Health and Human Services (DHHS), Division of Health Care Financing and Policy (DHCFP) as a part of the National Governors Association Policy Academy seeks a Medicaid Section 1115 Demonstration waiver from the U.S. Department of Health and Human Services and the Centers for Medicare and Medicaid Services (CMS) to implement an innovative, cost-effective approach to support the health of Nevada's youth population. The vision is a system of supportive youth intervention for Nevada's youth to transition the current crisis-based services to a system of early support. This program will reduce lifetime health care costs by reducing the number of youth who are utilizing the behavioral health system of care, juvenile justice services, parole and probation services and truancy. Promoting the highest level of social and community participation, this program will focus on the system of care including services that address the social determinants of a youth's life and assist both the parent and family in successfully integrating into a healthy community. This Demonstration develops a risk assessment and service program called REACH, Resources for the Advancement of Child Health, to achieve these goals. It consists of a rising risk assessment and a program which includes interventions comprised of program coordination, community integration, parent coaching and positive youth development. Improving Nevada's health system for youth strengthens families, ensures a better future for Nevada's youth, and ultimately improves the lives of the individuals and families living in our communities while reducing high end costs.

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

* Medicaid-eligible includes the CHIP population

of the disorder and subsequent diagnosis (75% of behavioral health diagnoses are diagnosed by age 24). This demonstration seeks to identify children within this window of opportunity. It will focus on supportive youth interventions which provide the opportunity to reduce or stop the trajectory to illness. Nevada's Demonstration will target youth for intervention services at the point when they have risk factors but have not yet demonstrated symptoms. In the words of the National Council for Community Behavioral Healthcare, prevention and early intervention need to occur "before costs escalate and the prospects of a happy, healthy life disintegrate."

Under this Demonstration, the state will assess youth before they are symptomatic, a group that would otherwise not receive services and provide them with a service package that encompasses comprehensive, non-traditional services. Nevada is working to take an evidence-based list of screening questions and combining them into a unique assessment that will have the ability to be completed in nontraditional settings/with nontraditional providers, located where the youth are, in an efficient manner. The assessment will include a rating system that has the goal of identifying children who have had life incidences that may put them more at risk of future issues, but who currently do not have symptoms. We are also taking a group of services, some social-based, and developing a service program. Our hypothesis for this research and demonstration waiver is that by using this unique assessment and service package we will demonstrate a preventative value, both increasing health and decreasing costly care. The potential of this proposal has been recognized throughout Nevada and is supported by the Governor's Office, Nevada Superintendent of Schools and the Commissioner of Insurance.

COMPONENTS OF THE PROPOSED TRANSFORMATION

RISING RISK ASSESSMENT

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

In order to establish a mandate that would require all youth to receive the rising risk assessment prior to entering 7th grade, the state will engage the insurance

* Medicaid-eligible includes the CHIP population

commissioner, the legislature and the community to implement this mandate. This will require unique training to the rising risk assessment and program process. Historically, behavioral health screening and identification have been the only means of identifying at risk children and is associated with significant stigma. By requiring rising risk assessments of all youth entering 7th grade, Nevada hopes to eliminate the stigma universally associated with behavioral health diagnoses.

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

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

- **The "no risk" group requires no further action.**

- **The "watch and wait" group receives a follow-up rising risk assessment six months following the initial rising risk assessment.**

- **The "rising risk" group will be enrolled in the REACH program for supportive youth intervention.**

* Medicaid-eligible includes the CHIP population

- **The "at risk" group will include youth who the rising risk assessment identify to potentially have behavioral health symptoms or to be in crisis. The assessment provider will refer the youth to the appropriate clinical provider unless the youth is in crisis in which case the rising risk assessment provider will engage the state's mobile crisis team.[°]**

The rising risk assessment provider will be independent to the program deliverer and will receive an assessment fee for: (1) conducting the rising risk assessment, (2) applying the predictive algorithm, (3) referral to a provider for primary care and/or REACH services if needed and (4) data entry for tracking purposes.

The REACH program providers will receive a per member per month (PMPM) payment for three months of service delivery. They will also receive an incentive payment when the youth completes the REACH program. All youth enrolled in the program will receive the entire REACH program package. The state requests guidance on how to design this incentive program and receive federal matching funds for these payments.

THE REACH PROGRAM

As part of this transformation, Nevada is seeking a new determinant to identify those youth who are rising risk. Rising risk is defined as youth who have a number of risk factors but who have not yet exhibited clinical or behavioral signs and symptoms. Medicaid-eligible youth who have received a rising risk assessment and have been determined rising risk would be eligible for the REACH program. The REACH program includes the following components:

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

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

* Medicaid-eligible includes the CHIP population

Under this Demonstration, the state is seeking the authority to claim federal Medicaid matching funds for an assessment and service package that does not meet the requirements of Medicaid-covered services under the Medicaid State Plan. By limiting the early rising risk assessment to a specific Medicaid group and allowing non-traditional providers to administer the rising risk assessment, the state seeks to waive the Comparability under the State Plan as this Demonstration limits this program based upon age/grade in school. The state is also requesting authority under the Demonstration to limit the REACH benefit package to only those Medicaid-eligible youth who have a determinant of rising risk based on their rising risk assessment.

INVESTMENT AND SUSTAINABILITY

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

SUMMARY OF PROGRAM ELEMENTS

This five year Demonstration will:

1) **Maintain Medicaid state plan eligibility;**
2) **Maintain Medicaid state plan benefits;**
3) **Allow the state to provide a customized rising risk assessment to detect a new determinant of rising risk to a subset of Medicaid beneficiaries, administered by traditional and non-traditional providers in a variety of locations;**
4) **Allow the state to provide the REACH program only to the Medicaid-eligible youth who qualify through the early behavioral health assessment and to claim federal matching funds for the REACH program;**
5) **Allow the state to reimburse traditional and non-traditional professionals for the rising risk assessment provided to Medicaid-eligible youth in a variety of settings;**
6) **Allow the state to receive federal match for a PMPM and incentive payment for the REACH program;**

* Medicaid-eligible includes the CHIP population

7) **Allow the state to receive federal match for an incentive payment for linking comprehensive physical and behavioral health assessments; and**
8) **Generate cost efficiencies for the state to support the long-term sustainability of the Medicaid program.**

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

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

Given the significant need, Nevada has made strengthening its behavioral health system a top priority. This 1115 Demonstration waiver is linked with the Governor's priority to improve behavioral health access and services for youth in Nevada as well as a number of ongoing initiatives geared at improving the health of our youth. Specifically, the Department of Health and Human Services (DHHS) has obtained a number of grants that align with the goal of this Demonstration to achieve a system of care that is rooted in early detection and intervention. For example, these projects will assist the state to expand the capacity of community-based providers, which will be a critical element to ensuring Medicaid-eligible youth who are assessed and determined to be rising risk or at risk and able to access necessary services.

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

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

* Medicaid-eligible includes the CHIP population

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

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

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

- **Tribal Health: This Section 1115 Demonstration waiver concept was presented at a recent Tribal Consultation with the DHCFP, and their board members responded positively to the information; there was discussion of integrating their current behavioral health program with the Demonstration's program as an effort to collaborate.**

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

For example:

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

* Medicaid-eligible includes the CHIP population

psychotic episodes in young people with early symptoms (Robert Wood Johnson Foundation, 2013).

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

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

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

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

In summary, the rationale for this Demonstration is the present need for a system transformation and a state that is ready for change. Research points to supporting

* Medicaid-eligible includes the CHIP population

the vision of a system built on prevention and supportive youth intervention. Numerous studies document cost savings tied to similar initiatives, however, regardless of the savings, the state's priority is the best health outcomes for Nevada's youth.

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

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

With the help of an independent evaluator, the DHCFP will develop a plan for evaluating and improving the effectiveness of this rising risk program for Medicaid-eligible youth, including key outcome and improvement measures. The DHCFP will identify validated Healthcare Effectiveness Data and Information Set (HEDIS) and/ or External Quality Review Organization (EQRO) measures that adequately assess the impact of the program including reductions in higher levels of behavioral and physical health care and increases in supportive youth intervention service utilization. The state expects that by identifying rising risk youth and providing supportive youth services, youth will avoid the need for accessing more intensive services at a later date. Accordingly, the DHCFP will measure the impact of the Demonstration in terms of the reduction of: Emergency Room (ER) utilization, psychiatric hospitalizations, and Residential Treatment Center (RTC) stays or length of stay. These areas of measurement were chosen because they are high-cost, high level services where the largest improvement in health outcomes and cost reduction are expected. As listed above, literature supports the theory that early interventions can reduce the need for higher level services. The state will also assess how improved behavioral health can positively impact one's physical health in terms of comprehensive care. The DHCFP will examine the impact this program has on the number of Early Periodic Screening Diagnosis and Treatment (EPSDT) visits and improved access to other services, such as dental care. The state will evaluate the social impact of the REACH program by measuring the impacts to social

* Medicaid-eligible includes the CHIP population

determinants of health, such as truancy, usage of the juvenile justice system, high school drop-out and graduation rates, and future employment. A formal Evaluation Plan will be submitted to CMS.

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

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

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

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

The DHCFP is requesting a five year Demonstration plus an additional "year zero" at the beginning of the program. This accounts for an approximate nine month ramp up period to ensure training of assessors and providers of the rising risk assessment and REACH program. The goal is to provide the rising risk assessments in the spring, prior to the end of the school year. The following chart represents the proposed timeline:

* Medicaid-eligible includes the CHIP population

DEMONSTRATION YEAR	ACTIVITY	DATES
0	**Implementation:** • **MMIS update,** • **Assessor and REACH program training/Medicaid enrollment,** • **Statewide Database development,** • **Statewide rising risk assessment mandate,** • **Evaluation Plan developed** • **Hire additional DHCFP staff**	**November, 2015-July 2016**
1	**Enroll Medicaid-eligible youth who are entering 7th grade in Demonstration, rising risk assessment & REACH; Watch and Wait reassessed in 6 months. March, April & May, the rising risk assessments for the soon-to-be 7th graders will begin. Tracking 10-15 years olds.**	**August, 2016-July, 2017**
2	**Enroll new Medicaid-eligible 7th graders in Demonstration, rising risk assessment & REACH; Watch and Wait reassess in 6 months; assess new 7th graders in March, April & May; Tracking 10-16 year olds.**	**August, 2017-July, 2018**
3	**Enroll new Medicaid-**	**August, 2018-July, 2019**

* Medicaid-eligible includes the CHIP population

	eligible7th graders in Demonstration, rising risk assessment & REACH; Watch and Wait reassess in 6 months; assess new 7th graders in March, April & May; Tracking 10-17 year olds.	
4	**Enroll new Medicaid-eligible 7th graders in Demonstration, rising risk assessment & REACH services; Watch and Wait reassessed in 6 months; assess new 7th graders in March, April & May; Tracking 10-18 years olds.**	**August, 2019-July, 2020**
5	**Enroll new Medicaid-eligible 7th graders in Demonstration, rising risk assessment & REACH services; Watch and Wait reassessed in 6 months; assess new 7th graders in March, April & May; Tracking 10-19 years olds. Complete Evaluation Plan assessment.**	**August, 2020-July, 2021**

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

Subject to CMS approval, the DHCFP will develop rates for (1) providers administering the rising risk assessments and to Medicaid-eligible youth; and (2) the REACH's PMPM program for providers who render this package of services to the rising risk population who are Medicaid-eligible. The DHCFP will develop incentive payments for the rising risk assessors and REACH providers.

* Medicaid-eligible includes the CHIP population

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* Medicaid-eligible includes the CHIP population

Section II – Demonstration Eligibility

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

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

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

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

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

In addition to the State Plan services they are already eligible to receive, Medicaid-eligible youth entering the 7th grade will be eligible for a rising risk assessment [a customized version of the Child and Adolescent Needs and Strengths (CANS) assessment].*

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

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

* Medicaid-eligible includes the CHIP population

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

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

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

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

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

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

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

The state estimates approximately 14,000 youth (based upon FY15 CMS-416 data) will be eligible for the rising risk assessment in the first year of the Demonstration.

* Medicaid-eligible includes the CHIP population

This represents all Medicaid-eligible youth just prior to entering the 7th grade. Each year of the Demonstration, the new 7th graders will be introduced into the rising risk assessment phase of the program. This enrollment number is estimated to be similar to the first year's enrollment based upon the current enrollment in grades first through sixth. Estimates are as follows:

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

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

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

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

N/A

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

N/A

7) If applicable, describe any eligibility changes that the state is seeking to undertake for the purposes of transitioning Medicaid or CHIP eligibility standards to the methodologies or standards applicable in 2014 (such as financial methodologies for

* Medicaid-eligible includes the CHIP population

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

N/A

* Medicaid-eligible includes the CHIP population

Section III – Demonstration Benefits and Cost Sharing Requirements

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

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

The Demonstration utilizes an innovative approach to prevention and supportive youth intervention for Nevada's rising risk youth. Through numerous stakeholder meetings, it was determine that a customized version of the Child and Adolescent Needs and Strengths (CANS) assessment will be administered to all youth entering 7th grade. The rising risk assessment will be administered by traditional and non-traditional providers. Nevada's current system of health care does not identify the rising risk determinant and a new service model will be developed with this Demonstration. By incorporating non-traditional providers including school psychologists, school nurses, school social workers, school behavior specialists and behavioral specialist aides, community health workers, juvenile justice staff and parole & probation staff, we are utilizing providers located where the youth are located. One goal of this program is to identify our rising risk youth by expanding Nevada's network of non-traditional providers. This improves access to care and addresses a provider shortage.

Once the rising risk assessment is complete, youth that are identified as rising risk will be referred by the rising risk assessor to a REACH program provider. The REACH program provider monitors the youth through the REACH program, ensuring its completion. A bonus incentive will be awarded to the REACH program provider once the youth completes the entire program.

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

1) **REACH Coordination: coordination of the REACH program including mentoring, coaching, education and resources to REACH program children/families;**

* Medicaid-eligible includes the CHIP population

2) **Community Integration: health literacy, social supports, vocational supports, and recreational supports based on child/family needs in order to maintain or improve level of risk;**

3) **Positive Youth Development: opportunities for youth to build, enhance, and maintain skills, assets, and abilities; and**

4) **Parent Coaching: assists with daily life skills and supports achievement of objectives to maintain/reduce risk.**

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

N/A

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

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

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

* Medicaid-eligible includes the CHIP population

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

N/A

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

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

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

N/A

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

N/A

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

N/A

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

N/A

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

N/A

* Medicaid-eligible includes the CHIP population

Section IV – Delivery System and Payment Rates for Services

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

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

The Demonstration's delivery system consists of two components:

1. **The rising risk assessment using a customized version of the Child Adolescent Needs and Strength (CANS); and**

2. **The Resources for Early Advancement of Child Health (REACH) program**

See Attachment III-1 for chart of services.

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

Nevada is undertaking an overall system transformation by moving from a crisis-based system to an supportive youth intervention system. This transformation will result in delivery system reforms, most notably the introduction of a mandated rising risk assessment for all 7th graders, to be administered by both traditional and non-traditional providers. Schools, Family Resource Centers, juvenile justice, parole and probation, Federally Qualified Health Centers (FQHCs), school-based health centers and after school programs are all possible sites where the rising risk population could be identified and easily accessed. The state is transforming its delivery system to include non-traditional providers and settings as locations for the rising risk assessment. Traditional providers – both physical and behavioral health providers – will also administer the rising risk assessment in their usual practice settings and refer to appropriate services. By tapping into both traditional and non-traditional providers for conducting the rising risk assessment, the state's capacity for health evaluation expands. When a youth enters 7th grade they will receive the rising risk

* Medicaid-eligible includes the CHIP population

assessment. As described above, this will place a youth in one of four categories. Youth who are in the no risk category have completed the process and no further action will be taken. Youth who are in the watch and wait category will be re-evaluated in six months. Depending on the score, they will remain in the watch and wait or move up to either the rising risk or at risk category.

If the youth is determined to be rising risk, they will be referred to a REACH program provider. The REACH program includes the following:

1) **REACH Coordination: coordination of the REACH program including mentoring, coaching, education and resources to REACH program children/families;**

2) **Community Integration: health literacy, social supports, vocational supports, and recreational supports based on child/family needs in order to maintain or improve level of risk;**

3) **Positive Youth Development: opportunities for youth to build, enhance, and maintain skills, assets, and abilities; and**

4) **Parent coaching: assists with daily life skills and supports achievement of objectives to maintain/reduce risk.**

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

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

* Medicaid-eligible includes the CHIP population

Each outcome resulting from the rising risk assessment leads to a process referring the individual to the appropriate level of services.

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

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

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

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

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

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

* Medicaid-eligible includes the CHIP population

N/A;

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

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

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

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

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

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

N/A

7) If the Demonstration will provide personal care and/or long term services and supports, please indicate whether self-direction opportunities are available under the Demonstration. If yes, please describe the opportunities that will be available, and also provide additional information with respect to the person-centered services in the Demonstration and any financial management services that will be provided under the Demonstration (if additional space is needed, please supplement your answer with a Word attachment).

N/A

8) If fee-for-service payment will be made for any services, specify any deviation from State plan provider payment rates. If the services are not otherwise covered under

* Medicaid-eligible includes the CHIP population

the State plan, please specify the rate methodology (if additional space is needed, please supplement your answer with a Word attachment);

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

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

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

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

N/A

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

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

* Medicaid-eligible includes the CHIP population

Section V – Implementation of Demonstration

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

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

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

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

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

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

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

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

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

* Medicaid-eligible includes the CHIP population

Section VI – Demonstration Financing and Budget Neutrality

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

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

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

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

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

Medicaid enrollment will not be affected by this program. It is anticipated that approximately 14,000 youth will receive an initial CANS assessment and 2,800 of these youth (Watch and Wait) will receive a follow-up CANS assessment annually. This combines to a total annual cost of $516,936 at 100% participation. Of the 14,000, 2,100 are expected to fall into the Rising Risk determination, making them eligible for the REACH program at an annual cost of $1,890,000 with 100% participation. Operational costs are estimated to be $1,526,750 for the implementation year (year zero) and $965,500 the following years. The total expenditures for the five year Demonstration at 100% participation is $18,388,930.

Total Expenditures & Enrollment

	Enroll-ment Esti--mate (CANS)	Cost of CANS $30.77/ea	# predicted as Watch & Wait	Cost for 2nd W&W CANS $30.77/ea	# pre-dicted as Rising Risk	REACH program $300 PMPM for RR (3 mos.)	Admin. Costs	Total Expenditures
Year 0							$ 1,526,750	$ 1,526,750
Year 1	14,000	$ 430,780	2,800	$ 86,156	2,100	$ 1,890,000	$ 965,500	$ 3,372,436
Year 2	14,000	$ 430,780	2,800	$ 86,156	2,100	$ 1,890,000	$ 965,500	$ 3,372,436
Year 3	14,000	$ 430,780	2,800	$ 86,156	2,100	$ 1,890,000	$ 965,500	$ 3,372,436
Year 4	14,000	$ 430,780	2,800	$ 86,156	2,100	$ 1,890,000	$ 965,500	$ 3,372,436
Year 5	14,000	$ 430,780	2,800	$ 86,156	2,100	$ 1,890,000	$ 965,500	$ 3,372,436
total	70,000	$ 2,153,900	14,000	$ 30,780	10,500	$ 9,450,000	$ 6,354,250	$ 18,388,930

* Medicaid-eligible includes the CHIP population

References

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

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

The requested Budget Neutrality forms are included as separate attachments to this application submission.

* Medicaid-eligible includes the CHIP population

Section VII – List of Proposed Waivers and Expenditure Authorities

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

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

Waivers:

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

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

Expenditure authorities:

- **To allow the state to receive federal match for the reimbursement of traditional and non-traditional professionals for the rising risk assessments to Medicaid-eligible 7th graders in a variety of settings; and**
- **To allow the state to receive federal match for a PMPM and incentive payment for the REACH program.**

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

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

The State of Nevada requests that CMS waive the comparability requirements to allow the demonstration rising risk assessment and REACH program to be available to only a select group of children.

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

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

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

* Medicaid-eligible includes the CHIP population

Section VIII – Public Notice

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

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

August 7, 2015 through September 10, 2015

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

The DHCFP's website: http://dhcfp.nv.gov/
Public Notice link: http://dhcfp.nv.gov/Public/AdminSupport/PublicNotices/
The DHCFP webpage dedicated to this project and application:
http://dhcfp.nv.gov/Pgms/CPT/NGA-Youth/

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

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

One workshop was held on August 7, 2015, however the timing of the workshop and the posting of the application on the same date were too close to meet the requirement of posting prior to the workshop. Two public workshops meeting the CMS requirements were held on August 11 and August 18, 2015.

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These post-posting workshops were identical in content. The PowerPoint presentation used during this workshop can be found along with the public notice link with the application. The workshops included an overview of the project assessments and REACH program), a timeline of the project including both internal and external processes that must take place including provider training, enrollment and outreach, a funding discussion and a period for open comments on the 1115 Demonstration application and any comments related to any Nevada Medicaid. The workshops were held in Carson City, NV and videoconferenced to multiple sites (Elko, NV & Las Vegas, NV; the Reno location utilized the call-in number due to technical problems with video conferencing) and a call-in number was also provided for those who could not attend in person.

Link to Public Notices of workshops, documents and presentation:
http://dhcfp.nv.gov/Public/AdminSupport/PublicNotices/

Application posting:
http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Public/AdminSupport/1115DemonstrationWaiverApplicationPublicForumAgenda8-07-15.pdf

8/11/15 workshop notice/agenda

http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Public/AdminSupport/Revised1115DemonstrationWaiverApplicationPublicForumAgenda8-11-15.pdf

8/18/15 workshop notice/agenda

http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Public/AdminSupport/NGA_Public_Forum_Agenda_8_18_15.pdf

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

The state released a list serve linked to behavioral health and children to notify the public of the workshops.

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

* Medicaid-eligible includes the CHIP population

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

The State's response to items 5 & 6:

The following email address was provided to attendees of our workshops as a mean to provide any comments related to project and waiver application. It can also be found on the project's web page.
NGABHYouth@dhcfp.nv.gov

Comments:
During the posting period, the DHCFP received one email:
Tuesday 8/18/15
Hello, I appreciated today's public hearing but wanted to see if I could get an electronic copy of the PowerPoint used today entitled "Medicaid Transformation for Behavioral Health in Youth". I was able to find the Demonstration Application, but not the PowerPoint.

The PowerPoint was emailed to the author of the email.

PUBLIC WORKSHOP IN-PERSON COMMENTS (SUMMARY)
8/11/15

COMMENTS	STATE RESPONSES
Are you limited to CPEs (Certified Public Expenditures and IGTs (Intergovernmental transfers) as your post-demonstration funding strategies?	No, those are just a couple of funding ideas. The goal is to make the program sustainable after five years. We welcome any ideas.
The idea of outreaching across departments---what about the juvenile justice system? Even though I worked in juvenile justice, I felt like I was doing health literacy, reproductive health issues. I was wondering if that was in the mix?	Absolutely it is; We do consider them to be one of the non-traditional providers. One of the providers listed in the application is juvenile justice---on the parole and probation side.
What about the court system and the judiciary system too? They do a lot of diversionary kinds of services.	Absolutely, it's (your comment) greatly appreciated. Our juvenile justice system employees are providers for us. We utilize them for case management.
I know previously you talked about non-traditional services such as parenting and in-home support and services programs that are not currently necessarily Medicaid,	We've not dove into the operational aspect of this. We are still at the very high level---the 10,000 foot concept level. In the application, we are presenting the concept

* Medicaid-eligible includes the CHIP population

diagnosed reimbursable services, have you thought about how you're going to choose providers in terms of implementing those services and just the whole process as to how to get there. I think it's a great opportunity to get into impacting families before they get into crisis. Just wondering if you identified a process of how you're going to identify providers and what the criteria would be to become enrolled as a provider of these services?	to the Centers for Medicare and Medicaid Services of reaching these rising risk children who have not been diagnosed yet. We are not at the operational, internal procedures which can be seen on slide 10 which mentions identifying enrollment procedures
Have you spoken with the Division of Insurance regarding the statewide mandate?	Yes, our Administrator has contacted their Administrator and the initial response was supportive. We will need to continue those conversations.

PUBLIC WORKSHOP IN-PERSON COMMENTS (SUMMARY)
8/18/15

COMMENTS	STATE RESPONSES
2 part question: How do you plan on handling both the difference between managed care and fee-for-service; with statewide obviously you've got two urban counties that are managed care companies and fee-for-service? Considering how you're talking about non-traditional providers, I was wondering how you're work with them-–do you see issues with trying to blend staff providers being able to bill for Medicaid? Obviously we're going to have issues with non-traditional providers getting signed up to be Medicaid providers.	For the Demonstration period, we are making this a carve out of managed care so for all children this would be covered by fee-for-service. Year zero focuses on the enrollment aspect on non-traditional providers. Developing the structure as to how to bring them into our Medicaid system. There will be a large focus on targeted outreach. We have a really nice opportunity with what they call year zero. And we haven't done a lot of this across the nation with demonstration grants, but it really will be a fast and furious targeting during year zero before we start delivering the services.
How do you plan on—if you're looking at evaluations—how can you ensure that every kid gets evaluated?	I believe this is a database question. Obviously, with a mandate, we expect most children to receive the evaluation. There is always an opt out option for parent who choose not to have their youth participate, but otherwise there would have to be documentation of some sort that the child

* Medicaid-eligible includes the CHIP population

	received the evaluation. I know in the Web IZ system, it's very easy to look that up and make sure that they had that Tdap vaccination; there would probably be something similar where the school would have access to the system and they could identify---it would be HIPAA compliant—there would be information indicating that the screening had been done or they could produce something from their pediatrician if they chose to do that. We would also expect that some home-schooled children and some private school children---they they did not do it through the school, there would be a way that they would document that they had it done as well.

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

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

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

The tribes were included in the list serve that went out announcing the public workshops for this 1115 Demonstration application posting.

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

N/A

* Medicaid-eligible includes the CHIP population

Section IX – Demonstration Administration

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

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

Nevada Division of Health Care Financing and Policy

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

Email Address: **jenni.bonk@dhcfp.nv.gov**

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

Non –traditional provider qualifications proposed for all services:

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

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

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

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Benefit Specifications and Provider Qualifications

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

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

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

The CANS is a screening tool that examines risk factors for the following:

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

The CANS has a prediction algorithm built into it which will provide a "without waiver" estimation to predict where this youth might end up without services such as the REACH program.

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

Each Medicaid/CHIP-eligible child will be screened once with the CANS around 7th grade. The watch and wait group will receive a second screening six months following the initial CANS screening.

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

Service Limitations: **See above**

Provider Category:

Individual

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

Provider Qualifications:

Documented training and certification on performing the Nevada-modified CANS

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Benefit Specifications and Provider Qualifications

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

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

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

The REACH program consists of the following elements:

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

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

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

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

Service Limitations: **See above**

Provider Category:

Individual

Description of allowable providers/provider qualifications:

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

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

- **Resource Centers**
- **FQHCs/RHCs**
- **School s**
- **Boys and Girls Clubs**
- **Juvenile Justice**
- **Primary Care Settings**

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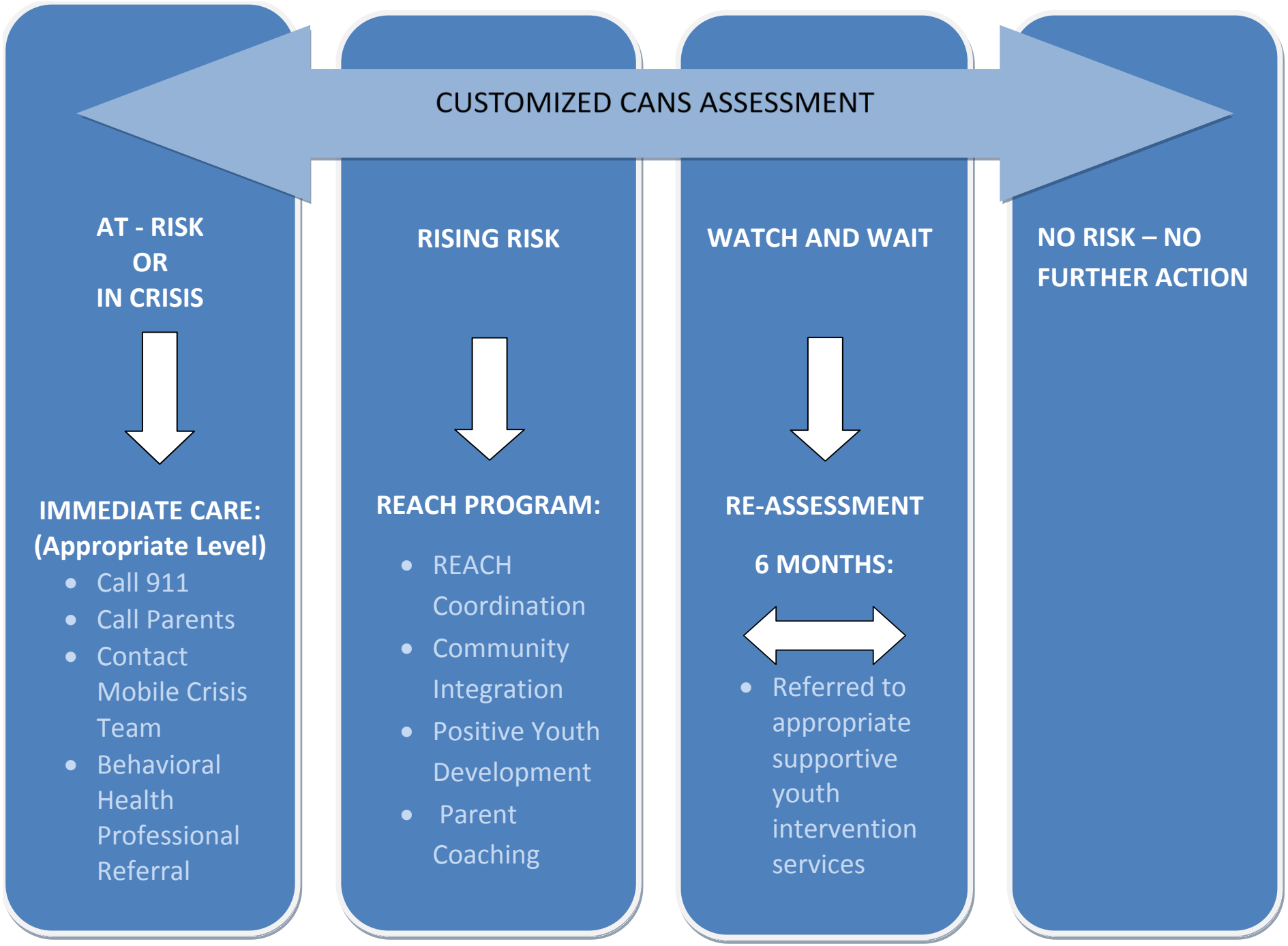

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September 11, 2015

Jenni Bonk
State of Nevada, DHCFP
1100 East William Street, No. 116
Carson City, NV 89701

Re: Development of Budget Neutrality Cost for Transformation Youth Behavioral Health Program

Dear Jenni:

This letter will describe the calculation performed to determine an appropriate cost for entry in CMS' budget neutrality template for DHCFP's upcoming Transforming Youth Behavioral Health (Youth BH) program. The calculation has been included in the budget neutrality workbook ("WW-CMS" and "Summary-CMS"). This letter explains the calculation in that exhibit; it may not be appropriate for other purposes. This letter replaces the analysis sent September 1st.

Executive Summary

As a part of discussions with CMS regarding budget neutrality requirements for DHCFP's upcoming Youth BH program, DHCFP is required to show that the program will be budget neutral in the long term. This document illustrates the development of projected savings for the first five program years, State Fiscal Year (SFY) 2017 to SFY 2021. Each section title below refers to a tab included in the "Youth BH Budget Neutrality.xlsb" file provided separately.

There were four main changes from the version of this analysis delivered September 1st, 2015:

1. Our assumption of MH claims eligible for savings was revised to reflect expectations that 87.5% of "Rising Risk" members will participate.
2. Implementation factors were adjusted to 20%, 40%, 60%, 80%, and 100% for years 1-5, respectively , reflecting feedback from DHCFP.
    a. For the September 1st deliverable, we reduced the implementation factors recognizing that only 20% of members in the target age range will be screened in any year (based on school grade level). This means it will take five years for the entire cohort to receive screening.
    b. In the September 1st deliverable, the factors were further reduced based on the expectation that savings would not be fully achieved in the first year after screening. However, after further review of the studies upon which the assumptions underlying this analysis are based, it was confirmed that the savings are first year savings. .
3. We assumed a membership growth of 5% per year based on research by DHCFP.
4. We adjusted the cost of the program to include DSHP funding needs in addition to the screening and treatment costs included previously.

Historic Medicaid Pops

The first tab included in the budget neutrality workbook for CMS is called "Historic Medicaid Pops". This tab summarizes the members eligible and their medical costs for 10 to 19 year olds from SFY 2010 to SFY2014. This tab was developed using the following steps:

- We used membership data provided by the State in May 2015 to identify all Nevada Medicaid members from SFY 2010 to SFY2014.
- We used claims data provided by the State for FFS claims incurred through April 2015 and Managed Care claims provided by Health Plan of Nevada (HPN) and Amerigroup form CY2015 rate setting. (This included claims paid through July 2014 for HPN and August 2015 for Amerigroup.)
- We limited all membership and claims to members 10 to 19 years old. This filter was applied by month based on the member's age at the first day of the month.
- We summarized the eligible member months and paid claims by fiscal year. We separated these values into two population sub-groups. The first group, titled "Standard", consists of children eligible under the eligibility criteria relevant for TANF, CheckUp, and the Medicaid Expansion population. The second group, referred to as "Medically Needy", represent all other children, including those eligibility under Aged/Blind/Disabled (ABD) criteria. The results are shown in the "Eligible Member Months" and "Total Expenditures" rows of the exhibit.

WOW – CMS

The next tab in the workbook is the "Without Waiver" projected cost for 10 to 19 year olds from SFY2017 to SFY2021. The projected eligibles in each year are the SFY 2014 eligible member months (from the "Historic Medicaid Pops" tab) trended at 5% per year. The total expenditures are the SFY 2014 total expenditures (from the "Historic Medicaid Pops" tab) trended at 5% per year and adjusted for the Medicaid fee schedule changes effective in July 2015. For future years we have assumed a 0% PMPM cost trend. According to CMS' instructions regarding the budget neutrality template, claims trend should be the lesser of historical trend or the President's budget trend. However, based on previous dealings with CMS, it is our understanding that 0% trend may be used in cases where historical trend is negative.

WW – CMS

The next tab in the workbook is the "With Waiver" projected cost for 10 to 19 year olds from SFY2017 to SFY2021. The projected eligibles in each year are the same eligibles shown in the "Without Waiver" tab. The projected costs with the waiver are based on the projected savings shown in Exhibit 1. This exhibit illustrates the starting (without waiver) cost, with adjustments as described below.

- We have assumed each of the projected savings amounts described below represent savings for the population engaged in a management program. Therefore, to calculate savings for the Medicaid population, it is necessary to estimate the percentage of behavioral health costs that would be generated by program participants. Based on a study published in the Journal of Child Psychology and Psychiatry, we have estimated that the 15% of the child population expected to participate in the program would generate approximately 39% of behavioral health costs in the population.
- We have assumed that 87.5% of members identified as "Rising Risk" will enroll in treatment.
- For each of these savings categories, the PMPM savings shown in Exhibit 1 is calculated as

Overall PMPM x Relevant Costs as a % of Total x % of Behavioral Health Costs Generated by Target Population x Participation Adjustment x Savings % x Implementation factor

  - "*Overall PMPM*" is the total PMPM shown in the Without Waiver tab
  - "*Relevant Costs as a % of Total*" and "*Savings %*" are different for each savings category, and are listed with the category descriptions below
  - "*% of Behavioral Health Costs Generated by Target Population*" is the 39% described above.
  - "*Participation Adjustment*" is the 87.5% described above.
  - "*Implementation factor*" differs by program year, and is shown in Exhibit 1

- The categories of assumed savings include:
    - Emergency Room Savings: Based on research provided by the State, it is expected that 57% of all psychiatric ER visits can be eliminated by early intervention. To project total ER psychiatric costs, we looked at all ER claims with a psychiatric diagnosis from SFY 2010 to SFY 2014 as a percent of total SFY 2010 to SFY 2014 costs (or approximately 0.3%).
        - Relevant Costs as % of total = 0.3%
        - Savings % = 57%
    - Residential Treatment Center (RTC) Savings: A similar approach was taken for the RTC savings. Based on historical data we found that approximately 15.0% of costs for 10 to 19 year olds in the Medicaid population come from RTCs. Research found by the State showed projected savings of 29% of RTC costs could result from early intervention.
        - Relevant Costs as % of total = 15.0%
        - Savings % = 29%
    - Inpatient Behavioral Health Savings: We found that 2.7% of 10 to 19 year old costs from SFY 2010 to SFY 2014 were from inpatient claims with Mental Health or Substance Abuse diagnoses. State research showed that early intervention could reduce these costs by 42%.
        - Relevant Costs as % of total = 2.7%
        - Savings % = 42%
- Final Costs of Screenings and Treatment: The State projected costs of screening and treatment based on projected engagement. We added the necessary DSHP funding as costs to this estimate to arrive at a total five year cost of $21,241,781. This was based on the total projected membership of the program, so we divided this cost by total member months to arrive at a PMPM cost of $2.85. We assumed the same PMPM cost per year for future program years.

The Net PMPM is the Without Waiver cost less ER savings, RTC savings, and Inpatient Behavioral Health savings, plus the cost of screening and treatment. The Net PMPM from Exhibit 1 is the With Waiver cost PMPM shown in the With Waiver tab of the budget neutrality workbook.

Limitations

In performing our analysis, we relied on data and other information provided to us by DHCFP and its data vendors. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison

of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Actual results will vary from our projections for many reasons, including differences from assumptions regarding provider fee schedules, the effectiveness of health care management and other cost savings programs such as fraud detection, as well as other random and non-random factors. Experience should continue to be monitored on a regular basis, with modifications to rates or to the program as necessary.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. We are members of the American Academy of Actuaries, and meet the qualification standards for performing the analysis in this letter.

Please contact us if you have any questions regarding this analysis.

Sincerely,

[redacted]

Robert Bachler, FSA, FCAS, MAAA
Principal and Consulting Actuary

[redacted]

Annie Hallum, FSA, MAAA
Actuary

cc: Betsy Aiello (DHCFP)
Colleen Lawrence (DHCFP)

Attachment

Exhibit 1
Budget Neutrality Evaluation
Projected Savings Development

Standard Population

	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	Notes
Without Waiver PMPM	$77.77	$77.77	$77.77	$77.77	$77.77	(1)
Emergency Room Savings PMPM	($0.09)	($0.09)	($0.09)	($0.09)	($0.09)	(2)
Residential Treatment Center Savings	($0.18)	($0.18)	($0.18)	($0.18)	($0.18)	(3)
Inpatient Behavioral Health Savings	($0.05)	($0.05)	($0.05)	($0.05)	($0.05)	(4)
Implementation Factor	20%	40%	60%	80%	100%	(5)
Cost of Program/Required Savings	$2.85	2.85	2.85	2.85	2.85	(6)
Net PMPM	$80.57	$80.50	$80.44	$80.38	$80.31	(7)

Medically Needy Population

	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	Notes
Without Waiver PMPM	$677.96	$677.96	$677.96	$677.96	$677.96	(1)
Emergency Room Savings PMPM	($0.33)	($0.33)	($0.33)	($0.33)	($0.33)	(2)
Residential Treatment Center Savings	($12.56)	($12.56)	($12.56)	($12.56)	($12.56)	(3)
Inpatient Behavioral Health Savings	($3.27)	($3.27)	($3.27)	($3.27)	($3.27)	(4)
Implementation Factor	20%	40%	60%	80%	100%	(5)
Cost of Program/Required Savings	$2.85	2.85	2.85	2.85	2.85	(6)
Net PMPM	$677.59	$674.35	$671.12	$667.89	$664.66	(7)

(1) Projected FFS costs from Without Waiver Calculation
(2) Assumes savings of 57% on all ER psych visists and participation of 87.5% of identified rising risk members
(3) Assumes savings of 29% on all RTC related costs and participation of 87.5% of identified rising risk members
(4) Assumes savings of 42% on all Inpatient Psych and Mental Health stays and participation of 87.5% of identified rising risk members
(5) Savings are expected to increase as the population being served grows and due to costs being greater in future years.
(6) Cost of screening and treatment includes both the cost of screening and treatment and the DSHP estimate.
The five year total expected cost is $21,241,781. This gets divided by the five year member months for a total cost of $2.85 PMPM.
(7) = (1) + [(2) + (3) + (4)] * (5) + (6)
Represents the "with waiver" cost to be put into the Budget Neutrality calculation

Please provide historical cost and eligibity data on existing Medicaid populations that will be included in the Demonstration.

5 YEARS OF HISTORIC DATA

SPECIFY TIME PERIOD AND ELIGIBILITY GROUP SERVED:

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5-YEARS
"Standard" Children 10-19 Years Old						
TOTAL EXPENDITURES	$45,959,233	$56,004,516	$54,722,676	$52,820,579	$65,521,693	$ 275,028,697
ELIGIBLE MEMBER MONTHS	516,570	621,237	674,922	699,703	847,848	
PMPM COST	$ 88.97	$ 90.15	$ 81.08	$ 75.49	$ 77.28	
TREND RATES			**ANNUAL CHANGE**			**5-YEAR AVERAGE**
TOTAL EXPENDITURE		21.86%	-2.29%	-3.48%	24.05%	9.27%
ELIGIBLE MEMBER MONTHS		20.26%	8.64%	3.67%	21.17%	13.19%
PMPM COST		1.33%	-10.06%	-6.89%	2.37%	-3.46%

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5-YEARS
Medically Needy Children 10-19 Years Old						
TOTAL EXPENDITURES	$183,392,164	$169,351,274	$180,941,126	$196,292,926	$213,191,476	$ 943,168,965
ELIGIBLE MEMBER MONTHS	227,294	242,902	263,279	283,730	315,442	
PMPM COST	$ 806.85	$ 697.20	$ 687.26	$ 691.83	$ 675.85	
TREND RATES			**ANNUAL CHANGE**			**5-YEAR AVERAGE**
TOTAL EXPENDITURE		-7.66%	6.84%	8.48%	8.61%	3.84%
ELIGIBLE MEMBER MONTHS		6.87%	8.39%	7.77%	11.18%	8.54%
PMPM COST		-13.59%	-1.43%	0.66%	-2.31%	-4.33%

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION

MEDICAID POPULATIONS (If no existing Medicaid populations will participate in the demonstration, leave blank.)										
ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR SFY 2016	TREND RATE 2	DEMONSTRATION YEARS (DY) SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	TOTAL WOW
"Standard" Children 10-19 Years Old										
Total Expenditures	5.34%	24	72,700,313	5.00%	76,335,328.16	80,152,095	84,159,699	88,367,684	92,786,068	
Eligible Member Months	5.00%	24	934,752	5.00%	981,490	1,030,565	1,082,093	1,136,197	1,193,007	
PMPM Cost					$77.77	$77.77	$77.77	$77.77	$77.77	$77.77
Medically Needy Children 10-19 Years Old										
Total Expenditures	5.16%	24	235,778,320	5.00%	247,567,236	259,945,597	272,942,877	286,590,021	300,919,522	
Eligible Member Months	5.00%	24	347,775	5.00%	365,164	383,422	402,593	422,722	443,859	
PMPM Cost					$677.96	$677.96	$677.96	$677.96	$677.96	$677.96

NOTES

"Base Year" is the year immediately prior to the planned first year of the demonstration.

"Trend Rate 1" is the trend rate that projects from the last historical year to the Base Year. The default is to use the 5-year historical average trend.

"Months of Aging" equals the number of months of trend factor needed to trend from the last historical year to the Base Year. If the base year is the year immediately following the last historical year, Months of Aging" will be 12.

"Trend Rate 2" is the trend rate that projects all DYs, starting from the Base Year. The default is to use the 5-year historical average trend.

For hypothetical populations, without-waiver estimates are set by default to equal the with-waiver extimates.

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION

MEDICAID POPULATIONS (If no existing Medicaid populations will participate in the demonstration, leave blank.)										
ELIGIBILITY GROUP	**TREND RATE 1**	**MONTHS OF AGING**	**BASE YEAR SFY 2016**	**TREND RATE 2**	**DEMONSTRATION YEARS (DY) SFY 2017**	**SFY 2018**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**TOTAL WW**
"Standard" Children 10-19 Years Old										
Total Expenditures	5.34%	24	72,700,313	N/A	79,074,932	82,963,359	87,042,942	91,323,075	95,813,614	
Eligible Member Months	5.00%	24	934,752	5.00%	981,490	1,030,565	1,082,093	1,136,197	1,193,007	
PMPM Cost					$80.57	$80.50	$80.44	$80.38	$80.31	$80.43
Medically Needy Children 10-19 Years Old										
Total Expenditures	5.16%	24	235,778,320	N/A	247,429,739	258,562,319	270,189,583	282,333,167	295,015,636	
Eligible Member Months	5.00%	24	347,775	5.00%	365,164	383,422	402,593	422,722	443,859	
PMPM Cost					$677.59	$674.35	$671.12	$667.89	$664.66	$670.81

NOTES

For a per capita budget neutrality model, the trend for member months is the same in the with-waiver projections as in the without-waiver projections. This is the default setting.
New hypothetical populations are shown in both without-waiver and with-waiver projections.
New non-hypothetical populations only appear in the with-waiver projections. The State must show offsetting Medicaid savings to achieve budget neutrality.
Demo Trend Rates' are a blended rate reduction that accounts for Waiver and Non-Waiver polpuation and Waiver Capitation payments to achieve budget nuetrality.

Budget Neutrality Summary

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	
"Standard" Children 10-19 Years C	$ 76,335,328	$ 80,152,095	$ 84,159,699	$ 88,367,684	$ 92,786,068	$ 421,800,875
Medically Needy Children 10-19 Ye	$ 247,567,236	$ 259,945,597	$ 272,942,877	$ 286,590,021	$ 300,919,522	$ 1,367,965,253
TOTAL	$ 323,902,564	$ 340,097,692	$ 357,102,576	$ 374,957,705	$ 393,705,591	$ 1,789,766,128

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	
"Standard" Children 10-19 Years C	$ 79,074,932	$ 82,963,359	$ 87,042,942	$ 91,323,075	$ 95,813,614	$ 436,217,924
Medically Needy Children 10-19 Ye	$ 247,429,739	$ 258,562,319	$ 270,189,583	$ 282,333,167	$ 295,015,636	$ 1,353,530,444
TOTAL	$ 326,504,671	$ 341,525,679	$ 357,232,525	$ 373,656,243	$ 390,829,250	$ 1,789,748,367

TOTAL	$ (2,602,107)	$ (1,427,987)	$ (129,949)	$ 1,301,463	$ 2,876,340	$ 17,760

Exhibit 1
Budget Neutrality Evaluation
Projected Savings Development

Standard Population

	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	Notes
Without Waiver PMPM	$77.77	$77.77	$77.77	$77.77	$77.77	(1)
Emergency Room Savings PMPM	($0.09)	($0.09)	($0.09)	($0.09)	($0.09)	(2)
Residential Treatment Center Savings	($0.18)	($0.18)	($0.18)	($0.18)	($0.18)	(3)
Inpatient Behavioral Health Savings	($0.05)	($0.05)	($0.05)	($0.05)	($0.05)	(4)
Implementation Factor	20%	40%	60%	80%	100%	(5)
Cost of Program/Required Savings	$2.85	2.85	2.85	2.85	2.85	(6)
Net PMPM	$80.57	$80.50	$80.44	$80.38	$80.31	(7)

Medically Needy Population

	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	Notes
Without Waiver PMPM	$677.96	$677.96	$677.96	$677.96	$677.96	(1)
Emergency Room Savings PMPM	($0.33)	($0.33)	($0.33)	($0.33)	($0.33)	(2)
Residential Treatment Center Savings	($12.56)	($12.56)	($12.56)	($12.56)	($12.56)	(3)
Inpatient Behavioral Health Savings	($3.27)	($3.27)	($3.27)	($3.27)	($3.27)	(4)
Implementation Factor	20%	40%	60%	80%	100%	(5)
Cost of Program/Required Savings	$2.85	2.85	2.85	2.85	2.85	(6)
Net PMPM	$677.59	$674.35	$671.12	$667.89	$664.66	(7)

(1) Projected FFS costs from Without Waiver Calculation
(2) Assumes savings of 57% on all ER psych visists and participation of 87.5% of identified rising risk members
(3) Assumes savings of 29% on all RTC related costs and participation of 87.5% of identified rising risk members
(4) Assumes savings of 42% on all Inpatient Psych and Mental Health stays and participation of 87.5% of identified rising risk members
(5) Savings are expected to increase as the population being served grows and due to costs being greater in future years.
(6) Cost of screening and treatment includes both the cost of screening and treatment and the DSHP estimate.
The five year total expected cost is $21,241,781. This gets divided by the five year member months for a total cost of $2.85 PMPM.
(7) = (1) + [(2) + (3) + (4)] * (5) + (6)
Represents the "with waiver" cost to be put into the Budget Neutrality calculation