Application for

Section 1915(b) (4) Waiver
Fee-for-Service
Selective Contracting Programs

Nevada Certified Community Behavioral Health Clinic

Nevada Division of Health Care Financing and Policy

July 24, 2019

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Application for Section 1915(b) (4) Waiver Fee-for-Service (FFS) Selective Contracting Program

Facesheet

The State of **Nevada** requests a waiver/amendment under the authority of Section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

The name of the waiver program is **Certified Community Behavioral Health Clinic.**
(Please list each program name if the waiver authorizes more than one program.).

Type of request. This is:

X an initial request for new waiver. All sections are filled.
__ a request to amend an existing waiver, which modifies Section/Part __.
__ a renewal request.

Section A is:
__ replaced in full
__ carried over with no changes
__ changes noted in **BOLD.**

Section B is:
__ replaced in full
__ changes noted in **BOLD.**

Effective Dates: This waiver/renewal/amendment is requested for a period of **five** years beginning **October 1, 2019** and ending **September 30, 2024.**

State Contact: The State contact person for this waiver is **Cody Phinney** and can be reached by telephone at **775-684-3735**, or fax at **775-687-3893**, or e-mail at **cphinney@dhcfp.nv.gov**. (List for each program)

Section A – Waiver Program Description

Part I: Program Overview

Tribal Consultation:
Describe the efforts the State has made to ensure that Federally-recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal (if additional space is needed, please supplement your answer with a Word attachment).

Pursuant to Section 1902(a) (73) of the Act, Nevada Department of Health and Human Services (DHHS) consulted with the State's federally recognized Indian tribes, Indian health programs, and urban Indian health organizations prior to submission of this waiver. Consultation was conducted in accordance with the process outlined in the State's approved Medicaid State Plan (State Plan Amendment 10-013). Specifically, on June 13, 2019, a letter was sent to Tribal members outlining the State's intent to seek a Section 1915(b) (4) waiver to limit the number of Certified Community Behavioral Health Clinics (CCBHCs) enrolled as providers under the Nevada Medicaid program. Recipients were given 30 days to request in-person consultation meetings and/or submit official written comments and questions for State analysis, consideration of any issues raised, and time for discussion between the State and entities responding to the notification. The tribes did not request consultation related to CCBHC efforts during this 30 days. Finally, recipients informed of corresponding updates that would be made to the Nevada Medicaid Services Manual (MSM) and the Medicaid State Plan (SPA). A copy of said letter is available at https://tinyurl.com/y3ms8j7z. In addition to this formal notification process, Tribal entities have been active participants in discussions regarding expansion of the CCBHC model. For example, Tribal consultation meetings were held on March 10, 2017, and October 9, 2018, wherein the State presented and discussed its community integration strategic plan, which included CCBHC expansion. The most recent Tribal Consultation meeting was held on July 9, 2019 to discuss the CCBHC model. At this meeting the tribes supported the expansion efforts the state was attempting to make by adding the seven additional CCBHC providers. The State has also presented its plans at several public workshops, Regional Behavioral Health Board meetings, Governor's Accountability Task Force on the Opioid Crisis meetings, and local substance abuse task force meetings. Thus far, feedback on the proposed expansion has been positive and well-received.

Program Description:
Provide a brief description of the proposed selective contracting program or, if this is a request to amend an existing selective contracting waiver, the history of and changes requested to the existing program. Please include the estimated number of enrollees served throughout the waiver (if additional space is needed, please supplement your answer with a Word attachment).

The Nevada DHHS is requesting Centers for Medicare & Medicaid Services (CMS) authority for a five-year, Section 1915(b)(4) waiver to secure and expand statewide access to comprehensive behavioral health services for the most vulnerable Nevadans. Specifically, DHHS seeks authority to continue operating and expand the CCBHCs model as implemented in Nevada pursuant to the Section 223 Protecting Access to Medicare Act (PAMA) Demonstration (formerly referred to as Certified Community Behavioral Health Clinics or CCBHCs).

CCBHCs, a new provider type in Medicaid, are designed to provide a comprehensive range of mental health and SUD services to vulnerable individuals. CCBHCs are responsible for providing

nine specific service types, with an emphasis on the provision of 24-hour crisis care, utilization of evidence-based practices, care coordination and integration with physical health care. Since implementation of the Demonstration, Nevada has certified three CCHBO providers and expanded their scope to allow for the provision of Medicaid State Plan services in an integrated setting. This expanded scope includes Medication Assisted Treatment (MAT) and ambulatory withdrawal management; primary care services; 24/7 crisis intervention including mobile crisis; psychiatric rehabilitation services; Assertive Community Treatment; and self-help/peer services.

Upon approval of this waiver request, the State will work to finalize the CCBHC certification process to add a minimum of seven new sites, for a total of ten. Sites will be identified by the State and subject to the organizational requirements set forth in Section 223 of the PAMA. The State reserves the right to certify additional sites over the course of the waiver period, subject to the availability of State funding. No enrollment limits will be applied to the waiver and the State anticipates that approximately 15,199 patients per month will be served throughout the waiver period based on the following projections:

Table 1: Projected Enrollment

Federal Fiscal Year	Patients Per Month
FFY19	728
FFY20	2908
FFY21	2905
FFY22	2895
FFY23	2886
FFY24	2877
Total	15,199

The above figures were calculated using the FFY19 average number of patients per CCBHC per month; rural and urban CCBHC averages were calculated separately. The average number of patients per CCBHC per month was projected for future federal fiscal years by adjusting for the projected caseload changes in the Medicaid caseload provided by the DHHS Office of Analytics. Note, a slight decline in the Medicaid caseload is projected and therefore the average number of patients per CCBHC per month declines slightly during the forecast period. The resulting projected average number of patients per CCBHC per month is multiplied by the number of projected CCBHCs to get the projected patients per month shown in the table above.

Waiver Services:
Please list all existing State Plan services the State will provide through this selective contracting waiver (if additional space is needed, please supplement your answer with a Word attachment).

The CCBHC delivery model incorporates the provision of expanded and non-traditional biopsychosocial services in a behavioral health clinic. Services focus on whole person, integrated care and the coordination of quality care for improved health outcomes for recipients with behavioral health disorders through innovation and transformation of the way primary and behavioral health care is delivered. The CCBHC delivery model is designed to increase provider flexibility and improve the responsiveness of services to meet the needs of recipients served. CCBHCs must provide all services identified Attachment 1: CCBHC Allowable Services Grid,

which will be included in the Nevada Medicaid State Plan. Note, this State Plan Amendment (SPA) is currently under CMS informal review.

A. Statutory Authority

1. **Waiver Authority.** The State is seeking authority under the following subsection of 1915(b):

   X 1915(b) (4) – **FFS Selective Contracting program**

2. **Sections Waived.** The State requests a waiver of the following sections of 1902 of the Act:

   a. __ Section 1902(a)(1) Statewideness
   b. __ Section 1902(a)(10)(B) Comparability of Services
   c. X Section 1902(a)(23) Freedom of Choice
   d. __ Other Sections of 1902 – (please specify)

B. Delivery Systems

1. **Reimbursement.** Payment for the selective contracting program is:

   X the same as stipulated in the State Plan
   __ is different than stipulated in the State Plan (please describe):

2. **Procurement.** The State will select the contractor in the following manner:

   __ Competitive procurement
   __ Open cooperative procurement process
   __ Sole source procurement
   X Other (please describe):

CCBHC providers will be selected following a rigorous application and certification process consistent with the PAMA Demonstration. As described above, the State is seeking to add a minimum of seven new CCBHCO providers, for a total of ten; however, the State reserves the right to certify additional sites over the course of the waiver period, subject to the availability of State funding.

C. Restrictions of Freedom of Choice

1. **Provider Limitations.**

   __ Beneficiaries will be limited to a single provider in their service area.
   X Beneficiaries will be given a choice of providers in their service area.

The waiver program will operate statewide.

2. **State Standards.**

Detail any difference between the state standards that will be applied under this waiver and those detailed in the State Plan coverage or reimbursement documents (if additional space is needed, please supplement your answer with a Word attachment).

There are no differences between the state standards that will be applied under this waiver and those detailed in the State Plan coverage or reimbursement documents. Of note, the State intends to maintain a cost-based payment model, currently in effect under the PAMA Demonstration, with one modification. Specifically, the State will continue to utilize the Certified Clinic Prospective Payment System (CC PPS-1) methodology; however, rather than re-basing Waiver Year Two (WY2) rates to reflect WY1 cost experience, the State will apply the Medicare Economic Index (MEI) adjustment. This approach was allowable at the State's option under the PAMA Demonstration. The State also intends to continue providing Quality Incentive Payments (QIPs) (formerly referred to as Quality Bonus Payments) to CCBHCs using the same methodology as provided under the PAMA Demonstration. For new CCBHCs, QIPs will be provided through a "pay-for-reporting" (P4R) mechanism during WY1, and a "pay-for-performance" (P4P) mechanism beginning WY2. This reimbursement methodology will be included in the Nevada Medicaid State Plan, and the corresponding SPA is currently under CMS informal review.

D. Populations Included in Waiver
(May be modified as needed to fit the State's specific circumstances)

1. **Included Populations.** The following populations are included in the Waiver Program:

X 1931 Children and Related Populations
X 1931 Adults and Related Populations
X Blind/Disabled Adults and Related Populations
X Blind/Disabled Children and Related Populations
X Aged and Related Populations
X Foster Care Children
X TITLE XXI SCHIP Children

2. Excluded Populations. Indicate if any of the following populations are excluded from participating in the waiver:

__ Dual Eligible
__ Poverty Level Pregnant Women
__ Individuals with other insurance
X Individuals residing in a nursing facility or ICF/MR
__ Individuals enrolled in a managed care program
__ Individuals participating in a HCBS Waiver program
__ American Indian/Alaskan Native
__ Special Needs Children (State Defined). Please provide this definition.
__ Individuals receiving retroactive eligibility
X Other (Please define):

The following "other" populations are excluded from the waiver: (1) individuals that meet the level of care for an inpatient/institutional stay for the duration of their inpatient status; (2) Qualified Medicare Beneficiaries (QMB) under 1902(a)(10)(E)(i) and 1905(p); (3) Specified Low Income Medicare Beneficiaries (SLMB) under 1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii); (4) Qualified Disabled and Working Individuals (QDWI) under 1902(a)(10)(E)(ii), 1905(s), and 1905(p)(3)(A)(i); and (5) Qualifying Individuals under 1902(a)(10)(E)(iv), 1905(p)(3)(A)(ii), and 1860D-14(a)(3)(D).

Part II: Access, Provider Capacity and Utilization Standards

A. Timely Access Standards

Describe the standard that the State will adopt (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has adopted) defining timely Medicaid beneficiary access to the contracted services, i.e., what constitutes timely access to the service?

1. How does the state measure (or propose to measure) the timeliness of Medicaid beneficiary access to the services covered under the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment)?

Pursuant to the Nevada Division of Health Care Financing and Policy's (DHCFP) MSM Chapter 2703, Section 10(B)(2), CCBHCs be capable of verifying and reporting timely access to care such that: (1) recipients seeking an appointment for routine needs are provided an initial evaluation within 10 business days of the request; (2) recipients seeking an appointment for an urgent need are seen and initial evaluation completed within one business day; and (3) recipients with an emergency or crisis need receive immediate and appropriate action. In addition, the State will continue to collect and evaluate a number of quality measures related to timeliness of care (*See* Attachment 2) and may elect to remove and/or incorporate additional related measures moving forward. The complete MSM 2703, including general CCBHC access to care standards that must be met for purposes of certification (Section 7), can be found at https://tinyurl.com/y5ck2v3o.

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiaries are unable to access the contracted service in a timely fashion (if additional space is needed, please supplement your answer with a Word attachment).

Pursuant to the Nevada DHCFP's MSM Chapter 2703, Section 10, CCBHCs must operate under established bylaws and have board members that are representatives of the individuals being served in terms of demographic factors such as geographic area, race, ethnicity, sex, gender identity, disability, age and sexual orientation. In terms of representation of behavioral health disorders, CCBHCs must incorporate meaningful participation by adult consumers with mental illness, adults recovering from substance use disorders and family members of CCBHC consumers (i.e., 51% of the board are families, consumers or people in recovery from behavioral health conditions to provide meaningful input to the board about the CCBHC's policies, processes and services). CCBHCs are required to provide the board an annual financial audit and correction plan with the relevant management letter to address any deficiencies; and reports to verify timely access to care as described above (i.e., MSM Chapter 2703, Section 10(B)(2)). In order for CCBHC's to maintain certification from the Nevada Division of Public and Behavioral Health (DPBH), they must meet the aforementioned timeliness standards. The State will leverage various mechanisms to ensure timeliness standards are met including, but not limited to, regular CCBHC reporting requirements and onsite assessments. CCBHCs not meeting these requirements will be subject to corrective actions, up to and including loss of certification.

B. Provider Capacity Standards

Describe how the State will ensure (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has ensured) that its selective contracting program provides a sufficient supply of contracted providers to meet Medicaid beneficiaries' needs.

1. Provide a detailed capacity analysis of the number of providers (e.g., by type, or number of beds for facility-based programs), or vehicles (by type, per contractor for non-emergency transportation programs), needed per location or region to assure sufficient capacity under the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).

Nevada is seeking approval for a Section 1915(b)(4) waiver to preserve the State's CCBHC model, which was originally established under the PAMA Demonstration. This model was implemented in 2016 following an extensive planning period that included a comprehensive evaluation of existing behavioral health services (i.e., capacity, access, etc.) using DHHS data and community-based needs assessments. Planning activities suggested that the availability of primary health care and behavioral health care is a critical issue throughout Nevada, as evidenced by the following statistics:

- Nevada is ranked 48th among U.S. states for physicians per capita. Primary care physicians ranked 50th, family medicine/general practice ranked 46th, registered nurses ranked 51st, psychiatrists ranked 47th and psychologists ranked 41st.
- 911,684 Nevadans or 33.7% of the state's population reside in a federally designated primary medical care health professional shortage area (HPSA); nine of 17 of Nevada's counties qualify as single-county primary medical shortage areas.
- Approximately 50.6% of Nevada's population (142,476 residents) of rural and frontier Nevada reside in a primary medical care HPSA; nine of 14 rural and frontier counties are single-county primary medical care HPSAs.
- Approximately 53.3% of Nevadans (1.5 million) reside in a federally designated mental HPSA; 16 of 17 counties are single-county mental HPSA.
- 100% of the population (286,251 residents) of rural and frontier Nevada live in a mental HPSA; 14 of 14 rural and frontier counties are single- county mental HPSAs.

Once the program design was finalized, the DHHS Bureau of Health Care Quality and Compliance (HCQC) developed a certification process for potential CCBHCs with attention to quality of care, access and availability of services. In order to obtain and maintain certification, CCBHCs must meet a series of criteria to ensure sufficient capacity. For example, MSM Chapter 2703, Section 3(A) states that CCBHC providers must: (1) maintain locations that are accessible, safe and functional; (2) maintain outpatient clinic hours that include night and weekend hours; (3) provide outreach and engagement activities to assist beneficiaries in accessing services; and (4) coordinate access to transportation through the State's non-emergency transportation vendor.

2. Describe how the State will evaluate and ensure on an ongoing basis that providers are appropriately distributed throughout the geographic regions covered by the selective contracting program so that Medicaid beneficiaries have sufficient and timely access throughout the regions affected by the program (if additional space is needed, please supplement your answer with a Word attachment).

CCBHC providers will be selected following a rigorous application and certification process consistent with the PAMA Demonstration. Through this waiver, the State is seeking to add a minimum of seven new CCBHC providers, for a total of ten; however, the State reserves the right to certify additional sites over the course of the waiver period, subject to the availability of State funding. As noted above, a considerably high percentage of Nevadans live in HPSAs that would benefit from an enhancement of services; however, the State will continue to evaluate the availability of relevant providers and services when considering new CCBHC sites.

C. Utilization Standards

Describe the State's utilization standards specific to the selective contracting program.

1. How will the State (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State) regularly monitor(s) the selective contracting program to determine appropriate Medicaid beneficiary utilization, as defined by the utilization standard described above (if additional space is needed, please supplement your answer with a Word attachment)?

The State has sufficient capacity to ensure regular monitoring of CCBHC utilization. Data is routinely collected by the Nevada DHHS, Office of Public Health Informatics and Epidemiology (OPHIE) and the DHCFP, including Treatment Episode Date Set (TEDS), Uniform Reporting System (URS), Mental Health Statistics Improvement Program (MHSIP) and the State Medicaid Surveillance Utilization and Review (SUR) team. The latter specifically reviews CCBHC utilization patterns and trends quarterly. Finally, Nevada has enhanced its Medicaid Management Information System (MMIS) to accommodate a new Provider Type for CCBHCs and the use of a new encounter code and modifier to allow CCBHCs to bill for encounters and the discreet services provided during a visit and to ensure appropriate monitoring of CCBHC service delivery.

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiary utilization falls below the utilization standards described above (if additional space is needed, please supplement your answer with a Word attachment).

As a provider of Medicaid services, CCBHCs are subject to Medicaid contractor/provider requirements, which are monitored for compliance by the State's Medicaid SUR team. The SUR team is responsible for ensuring that appropriate Medicaid requirements are met and reviews all providers for compliance with program policies and procedures. The SUR has the authority to educate, recoup funds, sanction, suspend and/or terminate non-compliant providers accordingly.

Part III: Quality

A. Quality Standards and Contract Monitoring

1. Describe the State's quality measurement standards specific to the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment)

    a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

        i. Regularly monitor(s) the contracted providers to determine compliance with the State's quality standards for the selective contracting program.
        ii. Take(s) corrective action if there is a failure to comply.

The DHHS HCQC is State's regulatory agency that provides licensing/certification and oversight to health facilities and medical laboratories. HCQC developed the CCBHC certification process with attention to quality of care, access and availability of services. This process includes completion of an application and submission of documentation currently required for the licensure of behavioral health facilities (e.g., business licenses, lease agreements, a list of professional staff, etc.). In order to maintain their certification, CCBHCs must meet designated quality/outcome measures. At present, the State intends to continue collecting and evaluating all quality measures required under the PAMA Demonstration (*See* Attachment 2). However, our experience throughout the Demonstration indicates that data collection for some of these proscribed measures may be burdensome for some providers. As such, the State reserves the right to remove certain measures and/or incorporate additional National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set measures (NCQA/HEDIS), as well as state developed measures based on outcomes data from crisis services. In addition, all CCBHCs must submit Continuous Quality Improvement Plans (CQI) for State approval. These CQI plans must include suicide deaths or attempts, 30-day readmissions and all CCBHC-led quality measures. Finally, CCBHCs are expected to monitor and report fidelity to selected core evidence-based practices (EBPs) to address the needs of the populations served.

2. Describe the State's contract monitoring process specific to the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).

    a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

        i. Regularly monitor(s) the contracted providers to determine compliance with the contractual requirements of the selective contracting program.
        ii. Take(s) corrective action if there is a failure to comply.

The State maintains a multi-pronged approach to monitoring CCBHC compliance with certification criteria. First, the State provides oversight through technical assistance and training (e.g., CCBHC learning communities), as well as tailored support for individual CCBHCs post-certification to support implementation of EBPs and fidelity measures. Second, progress on CQI quality measures is regularly reviewed with CCBHCs to address areas of improvement. Third, joint on-site certification reviews with HCQC, the DPBH Bureau of Behavioral Health Wellness and Prevention, the University of Nevada's Center for the Application of Substance Abuse Technologies and Nevada Medicaid are conducted at least annually to ensure ongoing compliance. Should deficiencies be identified through any of the aforementioned mechanisms, HCQC has authority to place the CCBHC on a corrective action plan and to monitor progress toward remediating any issues or terminate certification. Finally, as described above, CCBHCs are subject to Medicaid contractor/provider requirements, which are monitored for compliance by the State's Medicaid SUR team. The SUR team is responsible for ensuring that appropriate Medicaid requirements are met and reviews all providers for compliance with program policies and procedures. The SUR team has the authority to educate, recoup funds, sanction, suspend and/or terminate non-compliant providers accordingly.

B. Coordination and Continuity of Care Standards

Describe how the State assures that coordination and continuity of care is not negatively impacted by the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).

The CCBHC model is designed to expand access to crisis evaluation, ambulatory detoxification services and outpatient stabilization for individuals who are appropriate for such services. For individuals with needs that exceed outpatient treatment, CCBHCs are required to provide coordinated referrals to higher levels of care in the community. Specifically, MSM Chapter 2703, Section 6, requires that CCBHCs must work on behalf of recipients in the coordination and management of their care to ensure effective outcomes. This includes all providers of behavioral/mental and physical health care and other agencies serving a joint recipient. CCBHCs must have polices in place that ensure: (1) coordination of care for recipients who present to the local emergency department or who are involved with law enforcement when in a crisis; (2) a reduction in any delays in the initiation of services during and after a recipient has experienced a psychiatric crisis; (3) coordination with all State of Nevada DHHS programs to maximize benefits to recipients served, eliminate duplication of efforts, streamline processes and improve access to available community supports; and (4) effective and timely care coordination by having appropriate consents in place that meet HIPAA and 42 CFR Part 2 requirements.

To ensure effective and timely care coordination, CCBHCs must also have agreements in place which describe the mutual expectations and responsibilities related to care coordination for each of the following providers unless the service is provided directly by the CCBHC:

- Federally Qualified Health Centers (FQHCs);
- Rural Health Clinics (RHCs), when relevant;
- The recipient's primary care provider and other recipient providers of health care to ensure physical health care needs are addressed;

- Ambulatory detoxification, medical detoxification, post detoxification step-down services and residential program(s) to include the ability to track the recipient's admission and discharge to these facilities;
- Emergency departments which includes having protocols for transitioning recipients from emergency departments and other emergency settings to a safe community setting, including the transfer of medical records, prescriptions, active follow-up, a plan for suicide and homicide prevention and safety, where appropriate, and the provision of peer services;
- Acute-care and psychiatric hospitals, including, outpatient clinics and urgent care centers;
- Local law enforcement, criminal justice agencies and facilities including drug, mental health, veterans and other specialty courts;
- Indian Health Services and tribal programs;
- Specialty providers of medications for treatment of opioid and alcohol disorders;
- Homeless shelters/housing agencies;
- Employment services systems;
- Services for children (e.g., schools, child welfare agencies, juvenile justice programs, etc.);
- Services for older adults, such as Aging and Disability Services Division;
- The nearest Department of Veterans Affairs' medical center, independent clinic, drop-in center or other VA facility; and
- Local human services programs (e.g., domestic violence centers, pastoral services, grief counseling, etc.).

In addition to the requirements noted above, several key CCBHC quality/outcome measures directly address care coordination including, but not limited to, "Follow-Up After Emergency Department Visit for Mental Illness" (FUM), "Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence" (FUA), "Follow-Up After Hospitalization for Mental Illness" (FUH-BH) and "Follow-Up Care for Children Prescribed ADHD Medication" (ADD-BH).

Part IV: Program Operations

A. Beneficiary Information

Describe how beneficiaries will get information about the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).

Pursuant to MSM Chapter 2703, Section 3(A)(8), CCBHCs must provide outreach and engagement activities to assist recipients and their families in accessing services. Existing CCBHCs have based beneficiary outreach activities on information received during community-based focus groups that included Medicaid recipients, law enforcement, school staff, etc. Additionally, DPBH maintains a website (http://dpbh.nv.gov/Reg/CCBHC/CCBHC-Main) that describes the CCBHC model, services provided, site locations, payment information (i.e., all patients will be seen regardless of ability to pay). As additional CCBHC sites are certified, DPBH will support provider efforts to engage beneficiaries in their service communities through public announcements, member notifications, provider bulletins, etc.

B. Individuals with Special Needs

__ The State has special processes in place for persons with special needs (Please provide detail).

Section B – Waiver Cost-Effectiveness & Efficiency

Efficient and economic provision of covered care and services:

1. Provide a description of the State's efficient and economic provision of covered care and services (if additional space is needed, please supplement your answer with a Word attachment).

Nevada's CCBHCs (two rural and one urban) have been operating under the PAMA Demonstration, which began in July 2017 and continues through June 2019. The projected waiver cost estimates provided are based on the number of CCBHCs growing from three to 10 during federal fiscal 2020 (FFY20). Average monthly payments per CCBHC are multiplied by the number of CCBHCs to determine projected expenditures.

To calculate average monthly costs per CCBHC, separate analysis was conducted for rural and urban CCBHCs. The average payments differ based on location because the urban CCBHCs typically see more patients and provide services to both fee-for-service and managed care recipients. The monthly average CCBHC patient counts are shown in Table 1 below:

Table 1: Average Patient Count

Federal Fiscal Year	Monthly Average CCBHC Patients		
	Rural	Urban	Total
FFY18	220	449	668
FFY19 YTD*	289	376	666

*Note: FFY19 includes data for July 2018 through May 2019.

The average payment per month per CCBHC is shown in Table 2 below. The FFY19 average payments are based on actual payments for July 2018 through May 2019. To calculate the average payment per CCBHC per month for future federal fiscal years, the FFY19 payment was grown using the Medicare Economic Index (MEI, December 13, 2018 release) and projected caseload growth rates from the Nevada DHHS Office of Analytics (May 2019 projection).

Table 2: Average Payment per Month per CCBHC

	Rural	Urban
FFY19	$140,825.69	$389,132.82
FFY20	$144,229.88	$407,756.91
FFY21	$148,334.83	$419,362.13
FFY22	$152,119.18	$430,060.99
FFY23	$156,327.57	$441,958.66
FFY24	$160,564.01	$453,935.64

Total projected payments under the "with waiver" scenario range between $33,119,207 in FFY20 to $36,869,979 in FFY24.

Without the waiver, the number of CCBHCs would increase over time, making it difficult to maintain fidelity to the model while controlling costs. Currently there are 448 urban and 60 rural Medicaid-enrolled SAPTA, FQHC and BHCN clinics. For the without waiver analysis, we assumed that half of all enrolled clinics would become CCBHCs over a period of 10 years. The projected number of CCBHCs would reach 133 by the end of FFY24. Table 3 below summarizes the two scenarios.

Table 3: With/Without Waiver Scenarios

State Fiscal Year	With Waiver		Without Waiver	
	CCBHCs	Expenditures	CCBHCs	Expenditures
FFY19	3	$8,157,410	3	$8,157,410
FFY20	10	$33,119,207	50	$71,534,063
FFY21	10	$34,061,818	104	$197,362,320
FFY22	10	$34,930,810	158	$332,049,080
FFY23	10	$35,897,174	212	$474,473,670
FFY24	10	$36,869,979	266	$624,180,966

2. Project the waiver expenditures for the upcoming waiver period.

Year 1 from: October 1, 2019 to September 30, 2020

Trend rate from current expenditures (or historical figures): 2.4%.

Projected pre-waiver cost $71,534,063
Projected Waiver cost $33,119,207

Difference: $38,414,856

Year 2 from: 10/01/20 to 09/30/21

Trend rate from current expenditures (or historical figures): 2.8%.

Projected pre-waiver cost $197,362,320
Projected Waiver cost $ 34,061,818

Difference: $163,300,502

Year 3 from: 10/01/21 to 09/30/22

Trend rate from current expenditures (or historical figures): 2.6%.

Projected pre-waiver cost $332,049,080
Projected Waiver cost $ 34,930,810
Difference: $297,118,270

Year 4 from: 10/01/22 to 09/30/23

Trend rate from current expenditures (or historical figures): 2.8%.

Projected pre-waiver cost	$474,473,670
Projected Waiver cost	$ 35,897,174
Difference:	$438,576,496

Year 5 from: 10/01/23 to 09/30/24

Trend rate from current expenditures (or historical figures): 2.7%.

Projected pre-waiver cost	$624,180,966
Projected Waiver cost	$ 36,869,979
Difference:	$587,310,987

Attachment 1: CCBHC Allowable Services Grid

Nevada CCBHC Allowable Services July 1, 2019				
CPT or HCPCS Code*		**DESCRIPTION**		
Crisis Intervention Services to include: 24 Hour Crisis Response with Crisis Intervention, Crisis Stabilization, and 24-hour Mobile Crisis Services				
Crisis Intervention				
H2011 H2011 GT/HT				
H2011, 90839/90840, 90846/90847/90849				
H0007		Alcohol and/or drug services; crisis intervention (outpatient)		
99218		Initial Observation Care, per day, for the E/M of a patient which requires these three key components: a detailed or comprehensive history, a detailed or comprehensive examination, and medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the patient's or family's needs. Usually, the problem(s) requiring admission to "observation status" are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit.		
99219		Initial Observation Care, per day, for the E/M of a patient which requires these three key components: a detailed or comprehensive history, a detailed or comprehensive examination, and medical decision-making moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the patient's or family's needs. Usually, the problem(s) requiring admission to "observation status" are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.		
99220		Initial Observation Care, per day, for the E/M of a patient which requires these three key components: a detailed or comprehensive history, a detailed or comprehensive examination, and medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the patient's or		

		family's needs. Usually, the problem(s) requiring admission to "observation status" are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.		
Est. Patient 99211-99215, New Patient 99201-99205				
Psychotherapy for Crisis/Crisis Stabilization				
90839		Psychotherapy for Crisis, first 60 mins		
90840		Psychotherapy for Crisis, each additional 30 mins		
24-Hour Mobile Crisis				
H2011 H2011 GT/HT		Crisis Intervention Service		
Behavioral Health Screening, Assessment, and Diagnosis including Assessment of Risk				
Behavioral Health Screening				
H0002		Behavioral Health Screening to determine eligibility for admission to treatment program (1 unit per assessment at least 30 minutes)		
H0049		Alcohol/drug screening (1 unit per screening)		
99408		Alcohol and/or Substance Abuse Screening		
99409		Alcohol and/or Substance Abuse Screening		
Interactive Complexity & Psychiatric Diagnostic Procedures				
90785		Interactive Complexity		
90791		Psychiatric Diagnostic Evaluation		
90792		Psychiatric Diagnostic Evaluation with Medical Services		
Evaluation & Management-Physician, NP's, PA's.				
90833		Psychotherapy, 30 mins, with pt and/or family member when performed with an E/M service.		
90836		Psychotherapy, 45 mins, with pt and/or family member when performed with an E/M service.		
90838		Psychotherapy, 60 mins, with pt and/or family member when performed with an E/M service.		
99201		Office or other outpatient visit for the E/M of a NEW PT, which requires three components: a problem focused history, a problem focused exam and straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. 10 mins face-to-face.		
99202		Office or other outpatient visit for the E/M of a NEW PT, which requires three components: a problem focused history, a problem focused exam and straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. 20 mins face-to-face.		

99203		Office or other outpatient visit for the E/M of a NEW PT, which requires three components: a problem focused history, a problem focused exam and medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. 30 mins face-to-face.	
99204		Office or other outpatient visit for the E/M of a NEW PT, which requires three components: a problem focused history, a problem focused exam and medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. 45 mins face-to-face.	
99205		Office or other outpatient visit for the E/M of a NEW PT, which requires three components: a problem focused history, a problem focused examination and medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. 60 mins face-to-face.	
99211		Office or other outpatient visit for the E/M of an ESTABLISHED patient that may not require the presence of a physician or other qualified healthcare professional. Usually, the presenting problems are minimal. Typically, five minutes are spent performing or supervising these services.	
99212		Office or other outpatient visit for the E/M of an ESTABLISHED patient, which requires at least two of these three key components: a problem focused history, a problem focused examination and straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the patient's problem(s) and/or family's needs. Usually, problem(s) are self-limited or minor. Typically, 10 minutes face-to-face.	
99213		Office or other outpatient visit for the E/M of an ESTABLISHED patient, which requires at least two of these three key components: a problem focused history, a problem focused examination and medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the patient's problem(s) and/or family's needs. Usually, problem(s) are low to moderate severity. Typically, 15 minutes face-to-face.	
99214		Office/outpatient visit est	
99215		Office or other outpatient visit for the E/M of an ESTABLISHED patient, which requires at least two of these three key components: a problem focused history, a problem focused examination and medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the patient's problem(s) and/or family's needs. Usually, problem(s) are of moderate to high severity. Typically, 40 minutes face-to-face.	
99217		Observation care discharge day management	
Psychological Assessment			
96101-96103		Psychological Testing	
96111		Developmental Testing	
96118-96120		Neuropsychological Testing	

96150-96151		Health and Behavior Assessment	
96161		Caregiver Health Risk Assessment, administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument.	
Behavioral Health Assessment			
H0031		Mental Health Assessment by Non-physician	
H0001		Alcohol and/or Drug Assessment (1 unit per assessment at least 30 minutes)	
96116		Neurobehavioral Status Exam	
Patient-Centered Treatment Planning or Similar Processes Including Risk Assessment and Crisis Planning			
96101-96103, 96111, 96118-96120, 96150-96151			
H2011 H2011 GT/HT		Crisis Intervention Service	
H0007		Risk Assessment (Suicidality); Alcohol and/or drug services; crisis intervention (outpatient)	
Outpatient Mental Health and Substance Abuse Treatment			
90832		Psychotherapy, 30 mins, with pt and/or family member	
90834		Psychotherapy, 45 mins, with pt and/or family member	
90837		Psychotherapy, 60 mins, with pt and/or family member	
90846		Family Psychotherapy (without the patient present)	
90847		Family Psychotherapy (conjoint therapy) (with patient present)	
90849		Multiple-Family Group Psychotherapy	
90853		Group Psychotherapy (other than of a multiple-family group)	
90875, 90876, 90901		Biofeedback Training	
90911		Biofeedback peri/uro/rectal	
H0004		Behavioral Health Counseling; in home or community setting	
H0004 HQ		Behavioral Health Counseling; in home or community setting; groups	
H0035		Mental Health; Partial Hospitalization, treatment less than 24 hours (1 unit equals 60 minutes)	
S9480		Intensive Outpatient Psychiatric Services, per diem	
H0005		Alcohol and/or Drug Services; group counseling by a clinician (1 unit per group at least 30 minutes)	
H0015		Alcohol and/or Drug Services; intensive outpatient program (3 hours per day at least 3 days per week) (1 unit equals 1 day/visit)	
H0020		Alcohol and/or Drug Services; methadone administration and/or service (provision of the drug by a licensed program)	
H0047		Alcohol and/or Drug Services; (State defined: individual counseling by a clinician). (1 unit per session at least 30 minutes)	
96152-96155		Health and Behavior Intervention	

Medication Management			
H0034		Medication Training and Support; per 15 minutes	
H0034 TD		Medication Training and Support; per 15 minutes; Registered Nurse QMHA	
96372		Therapeutic, prophylactic, or diagnostic injection; subcutaneous or intramuscular	
Medication Assisted Treatment			
Targeted Case Management			
T1016		Case Management for Non-SMI, Non-SED (Level I-II LOCUS/CASII)	
T1017		Targeted Case Management-Non-SED	
T1017		Targeted Case Management-SED	
T1017		Targeted Case Management-Non-SMI	
T1017		Targeted Case Management-SMI	
Outpatient Clinic Primary Care Screening and Monitoring of Key Indicators and Health Risk			
96127		Brief emotional/behavioral assessment (e.g., Depression inventory, ADHD) with scoring and documentation per standardized instrument	
80305		Drug test(s), presumptive, any number of drug classes, any number of devices or procedures (eg, immunoassay); capable of being read by direct optical observation only (eg, dipsticks, cups, cards, cartridges) includes sample validation when performed, per date of service.	
80306		Drug test(s), presumptive, any number of drug classes, any number of devices or procedures (eg, immunoassay); capable of being read by instrument assisted direct optical observation (eg, dipsticks, cups, cards, cartridges) includes sample validation when performed, per date of service.	
80307		Drug test(s), presumptive, any number of drug classes, any number of devices or procedures, by instrument chemistry analyzers (eg, utilizing immunoassay, [eg, EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (eg, GC, HPLC), and mass spectrometry either with or without chromatography, (eg, DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service.	
G0480		Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (eg, IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (eg, alcohol dehydrogenase)); qualitative or quantitative, all sources, includes specimen validity testing, per day, 1-7 drug class(es), including metabolite(s) if performed.	
G0481		Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (eg, IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (eg, alcohol dehydrogenase)); qualitative or quantitative, all sources, includes specimen validity testing, per day, 8-14 drug class(es), including metabolite(s) if performed.	

G0482		Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (eg, IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (eg, alcohol dehydrogenase)); qualitative or quantitative, all sources, includes specimen validity testing, per day, 15-21 drug class(es), including metabolite(s) if performed.)
G0483		Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomer's), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (eg, IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (eg, alcohol dehydrogenase)); qualitative or quantitative, all sources, includes specimen validity testing, per day, 22 or more drug class(es), including metabolite(s) if performed.
G0438		Annual Wellness Visit, including a personalized prevention plan of service, initial visit (21 & over)
G0439		Annual Wellness Visit, including a personalized prevention plan of service, subsequent visit (21 & over)
80061		Cardiovascular disease screening - lipid panel
82465		Cardiovascular disease screening - cholesterol, serum or whole blood, total
83718		Cardiovascular disease screening - lipoprotein, direct measurement; high density cholesterol (hdl)
84478		Cardiovascular disease screening - triglycerides
82947		Diabetes screening tests - glucose; quantitative, blood (except reagent strip)
82950		Diabetes screening tests - glucose; post glucose dose
82951		Diabetes screening tests - glucose; tolerance test, three specimens
Psychiatric Rehabilitation Services		
H2012		Behavioral Health Day Treatment (* Under an approved Model of Specialty 308)
H2014		Basic Skills Training
H2014 HQ		Basic Skills Training Group
H2017		Psychosocial Rehabilitation - PSR could be utilized to assist with development of a wellness recovery action plan (WRAP) for coping with crisis scenarios.
H2017 HQ		Psychosocial Rehabilitation Group - PSR could be utilized to assist with development of a wellness recovery action plan (WRAP) for coping with crisis scenarios.
98961		Education and training for patient self-management by a Qualified, non-physician health care professional using standardized curriculum, face-to-face with the patient (could include caregiver/family), each 30 min; individual
98962		Education and training for patient self-management by a Qualified, non-physician health care professional using standardized curriculum, face-to-face with the patient (could include caregiver/family), each 30 min; 5-8 patients
Behavior Change Intervention & Counseling Risk Factors		
99401		Preventive med counseling
99406		Smoking and tobacco cessation counseling

99407		Smoking and tobacco cessation counseling	
99420		Health risk assessment test	
99490		Chronic disease self-management (disease intervention, self-monitoring)	
G0108		Diabetes self-management; outpatient self-management training services, individual, per 30 minutes	
G0109		Diabetes self-management; outpatient self-management training services, group session, per 30 minutes	
H0038		Self-Help/Peer Service; per 15 minutes	
H0038		Self-Help/Peer Service; per 15 minutes; Use modifier HQ when requesting/billing for a group setting	
Place of Service: Providing services in the community and in non-traditional settings			
Q3014		Telehealth Originating site facility fee	

CCBHC/FQHC	
Services that may be performed under a CCBHC or FQHC. Care coordination would need to occur to prevent duplicative billing for the same service	
CPT or HCPCS Code*	**DESCRIPTION**
Labs	
80305	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures (eg, immunoassay); capable of being read by direct optical observation only (eg, dipsticks, cups, cards, cartridges) includes sample validation when performed, per date of service.
80306	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures (eg, immunoassay); capable of being read by instrument assisted direct optical observation (eg, dipsticks, cups, cards, cartridges) includes sample validation when performed, per date of service.
80307	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures, by instrument chemistry analyzers (eg, utilizing immunoassay, [eg, EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (eg, GC, HPLC), and mass spectrometry either with or without chromatography, (eg, DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service.
G0480	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (eg, IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (eg, alcohol dehydrogenase)); qualitative or quantitative, all sources, includes specimen validity testing, per day, 1-7 drug class(es), including metabolite(s) if performed.
G0481	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (eg, IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (eg, alcohol dehydrogenase)); qualitative or quantitative, all sources, includes specimen validity testing, per day, 8-14 drug class(es), including metabolite(s) if performed.
G0482	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (eg, IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (eg, alcohol dehydrogenase)); qualitative or quantitative, all sources, includes specimen validity testing, per day, 15-21 drug class(es), including metabolite(s) if performed.)
G0483	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomer's), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (eg, IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (eg, alcohol dehydrogenase)); qualitative or quantitative, all sources, includes specimen validity testing, per day, 22 or more drug class(es), including metabolite(s) if performed.

80061	Cardiovascular disease screening - lipid panel
82465	Cardiovascular disease screening - cholesterol, serum or whole blood, total
83718	Cardiovascular disease screening - lipoprotein, direct measurement; high density cholesterol (hdl)
84478	Cardiovascular disease screening - triglycerides
82947	Diabetes screening tests - glucose; quantitative, blood (except reagent strip)
82950	Diabetes screening tests - glucose; post glucose dose
82951	Diabetes screening tests - glucose; tolerance test, three specimens
Evaluation and Management	
99201	Office or other outpatient visit for the E/M of a NEW PT, which requires three components: a problem focused history, a problem focused exam and straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. 10 mins face-to-face.
99202	Office or other outpatient visit for the E/M of a NEW PT, which requires three components: a problem focused history, a problem focused exam and straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. 20 mins face-to-face.
99203	Office or other outpatient visit for the E/M of a NEW PT, which requires three components: a problem focused history, a problem focused exam and medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. 30 mins face-to-face.
99204	Office or other outpatient visit for the E/M of a NEW PT, which requires three components: a problem focused history, a problem focused exam and medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. 45 mins face-to-face.
99205	Office or other outpatient visit for the E/M of a NEW PT, which requires three components: a problem focused history, a problem focused examination and medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. 60 mins face-to-face.

99211	Office or other outpatient visit for the E/M of an ESTABLISHED patient, that may not require the presence of a physician or other qualified healthcare professional. Usually, the presenting problems are minimal. Typically, five minutes are spent performing or supervising these services.
99212	Office or other outpatient visit for the E/M of an ESTABLISHED patient, which requires at least two of these three key components: a problem focused history, a problem focused examination and straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the patient's problem(s) and/or family's needs. Usually, problem(s) are self-limited or minor. Typically, 10 minutes face-to-face.
99213	Office or other outpatient visit for the E/M of an ESTABLISHED patient, which requires at least two of these three key components: a problem focused history, a problem focused examination and medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the patient's problem(s) and/or family's needs. Usually, problem(s) are low to moderate severity. Typically, 15 minutes face-to-face.
99214	Office/outpatient visit est
99215	Office or other outpatient visit for the E/M of an ESTABLISHED patient, which requires at least two of these three key components: a problem focused history, a problem focused examination and medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the patient's problem(s) and/or family's needs. Usually, problem(s) are of moderate to high severity. Typically, 40 minutes face-to-face.
Behavior Change Intervention & Counseling Risk Factors	
96161	Caregiver Health Risk Assessment, administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument.
99401	Preventive med counseling
99406	Smoking and tobacco cessation counseling
99407	Smoking and tobacco cessation counseling
99490	Chronic disease self-management (disease intervention, self-monitoring)
G0108	Diabetes self-management; outpatient self-management training services, individual, per 30 minutes
G0109	Diabetes self-management; outpatient self-management training services, group session, per 30 minutes
96127	Brief emotional/behavioral assessment (e.g., Depression inventory, ADHD) with scoring and documentation per standardized instrument
96152-96155	Health and Behavior Intervention

FQHC Only Services	
Services deemed appropriate in the FQHC primary care setting only	
CPT Code	**Description**
Labs, vaccines and ancillary services	
81000	Urinalysis nonauto w/scope
81001	Urinalysis auto w/scope
81002	Urinalysis nonauto w/o scope
81003	Urinalysis auto w/o scope
81015	Microscopic exam of urine
81025	Urine pregnancy test
82948	Reagent strip/blood glucose
82962	Glucose blood test
83026	Hemoglobin
83036	HgA1c
84702	Chorionic gonadotropin test
84703	Chorionic gonadotropin assay
86308	Heterophile antibody screen
86331	Immunodiffusion ouchterlony
86580	Tb intradermal test
86702	Hiv-2 antibody
87340	Hepatitis B surface AG IA
87341	Hepatitis B surface AG IA
87800	Detect agnt mult dna direc
87880	Strep A assay w/optic
90471	Immunization admin
90472	Immunization admin each add
90473	Immune admin oral/nasal
90474	Immune admin oral/nasal addl
90690	Typhoid vaccine oral

90691	Typhoid vaccine im
90740	HepB vacc 3 dose immunsup im
90747	HepB vacc 4 dose immunsup im
90748	HIB-HEPB vaccine im
94010	Breathing capacity test
94060	Evaluation of wheezing
94150	Vital capacity test
94640	Airway inhalation treatment
90460	Immunization Administration through 18 years of age; first vaccine/toxoid component (Bill at the usual and customary charge)
90471	Vaccine Administration – Single
90472	Vaccine Administration – Each Additional Unit
90476-90748	Vaccines (Bill the appropriate vaccine code at a zero-dollar amount.) Providers must use Vaccines for Children (VFC) vaccines for children 18 and under.
90476	Vaccine for adenovirus oral admin, type 4
90477	Vaccine for adenovirus oral admin, type 7
99188	Application of fluoride varnish by physician or other qualified health care professional
80047-80076	Organ or Disease-oriented panel (bill the appropriate code)
36415	Routine Venipuncture
86631	Chlamydia antibody
86632	Chlamydia iGm
87110	Chlamydia culture any source
87270	Chlamydia antigen detection by immunoflourescent technique
87320	Chlamydia antigen detection by enzyme immunoassay technique
87490	Neisseria gonorrhea, direct probe technique
87491	Neisseria gonorrhea, amplified probe technique
87492	Neisseria gonorrhea, quantification
87801	Infectious agent detection by DNA or RNA, direct probe technique
87810	Chlamydia antigen detection by immunoassay with direct optical observation
87590	Neisseria gonorrhea, direct probe technique

87591	Neisseria gonorrhea, amplified probe technique
87592	Neisseria gonorrhea, quantification
87801	Infectious agent detection by DNA or RNA, direct probe technique
87850	Neisseria gonorrhea antigen detection by immunoassay with direct optical observation
86689	HIV antibody confirmatory test e.g. Western Blot
86701	HIV-1 antibody OR HIV-2 antibody
86703	HIV-1 & HIV-2 antibody
86592	Syphilis test, qualitative e.g. VDRL, RPR
86593	Syphilis test, quantitative e.g. VDRL, RPR
87623	Human Papillomavirus (HPV), low-risk types
87624	Human Papillomavirus (HPV), high-risk types
87625	Human Papillomavirus (HPV), types 16 and 18 only, includes type 45, if performed
G0432	HIV screening; infectious agent antigen detection by immunoassay technique
G0433	HIV screening; infectious agent antigen detection by enzyme-linked immunosorbent assay
G0435	HIV screening; infectious agent antigen detection by rapid antibody test
E&M and screenings	
90460	Immunization Administration through 18 years of age; first vaccine/toxoid component (Bill at the usual and customary charge)
90471	Vaccine Administration – Single
90472	Vaccine Administration – Each Additional Unit
90476-90748	Vaccines (Bill the appropriate vaccine code at a zero-dollar amount.) Providers must use Vaccines for Children (VFC) vaccines for children 18 and under.
90476	Vaccine for adenovirus oral admin, type 4
90477	Vaccine for adenovirus oral admin, type 7
96110	Developmental Screening
96161	Family Planning Service
99174	Amblyopia screening; Screening for amblyopia may be separately reimbursed along with an EPSDT screen.
99188	Application of fluoride varnish by physician or other qualified health care professional
99401	Caregiver Health Risk Assessment, administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument.

99381	New patient, infant (age under 1 year)	
99382	New patient, early childhood (age 1-4)	
99383	New patient, late childhood (age 5-11)	
99384	New patient, adolescent (age 12-17)	
99385	New patient, adult (age 18-20)	
99391	Established patient, infant (under 1 year)	
99392	Established patient, early childhood (age 1-4)	
99393	Established patient, late childhood (age 5-11)	
99394	Established patient, adolescent (age 12-17)	
99395	Established patient, adult (age 18-20)	
99401	Family Planning Service	
96110	Developmental Screening	
G0101	Cervical or vaginal cancer screening; pelvic and clinical breast exam	
G0102	Prostate cancer; digital rectal exam	
36415	Routine Venipuncture	
Occupational and Physical Therapy		
97165	Occupational Therapy Evaluation Low Complex 30 min	
97166	Occupational Therapy Evaluation Moderate Complex 45 min	
97167	Occupational Therapy Evaluation High Complex 60 min	
97168	Occupational Therapy Re-evaluation Plan Care 30 min	
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises	
97112	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation	
97150	Therapeutic procedures(s), group (a group is 2 to 4 individuals.)	

97530	Therapeutic activities, direct (one-to-one) patient contact by the provider (use of dynamic activities to improve the functional performance), each 15 minutes
97532	Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), each 15 minutes
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-to-one) contact by the provider, each 15 minutes
97535	Self-care/home management training (e.g., ADLs) direct (one-to-one) contact by the provider, each 15 minutes
97542	Wheelchair management/propulsion training, each 15 minutes

Attachment 2: 223 PAMA Demonstration Measures

Title	Definition	Measure Steward	NQF	Required Bonus Measure	Collector	Collection Method
Time to Initial Evaluation (I-EVAL)	The percentage of new consumers with an initial evaluation provided within 10 business days of first contact. The average number of days until initial evaluation for new consumers.	SAMHSA	NA	NA	CCBHC	Medical Records
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up (BMI-SF)	Percentage of consumers aged 18+ with: (1) a BMI documented during the current encounter or during the previous six months; and (2) a follow-up plan documented during the current encounter or in the six months prior.	CMS	0421	NA	CCBHC	Medical Records
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-BH)	Percentage of children ages three to 17 who had: (1) an outpatient visit with a primary care practitioner (PCP) or obstetrical/gynecological practitioner (OB/GYN) during the measurement year; and (2) evidence of a body mass index (BMI) percentile documentation during the measurement year.	NCQA	0024	NA	CCBHC	Administrative or Hybrid
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (TSC)	Percentage of consumers aged 18+ who: (1) were screened for tobacco use one or more times within 24 months; and (2) received cessation counseling intervention if identified as a tobacco user.	AMA-PCPI	0028	NA	CCBHC	Medical Records
Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	Percentage of consumers aged 18+ who: (1) were screened at least once within the last 24 months for unhealthy alcohol use using a systematic screening method; and (2) received brief counseling if identified as an unhealthy alcohol user.	AMA-PCPI	2152	NA	CCBHC	Medical Records
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C)	Percentage of consumer visits for those consumers aged six through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk.	AMA-PCPI	1365	Yes	CCBHC	Electronic Health Records
Major Depressive Disorder: Suicide Risk Assessment (SRA-A)	Percentage of consumers aged 18+ with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified.	AMA-PCPI	0104	Yes	CCBHC	Electronic Health Records or Medical Records

Title	Definition	Measure Steward	NQF	Required Bonus Measure	Collector	Collection Method
Screening for Clinical Depression and Follow-Up Plan (CDF-BH)	Percentage of consumers aged 12+ screened for clinical depression on the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.	CMS	0418	No	CCBHC	Hybrid
Depression Remission at Twelve Months (DEP-REM-12)	Adult consumers aged 18+ with major depression or dysthymia who reached remission 12 months (±30 days) after an index visit.	Minnesota Community Measurement	0710	No	CCBHC	Medical Records
Housing Status (HOU)	Percentage of consumers in 10 categories of living situation.	SAMHSA	NA	NA	State	Uniform Reporting System Data
Patient Experience of Care Survey (PEC)	Annual completion and submission of Mental Health Statistics Improvement Program (MHSIP) Adult Consumer Experience of Care Survey, identifying results separately for BHCs and comparison clinics and oversampling those clinics.	SAMHSA	NA	NA	State	MHSIP Survey
Youth/Family Experience of Care Survey (Y/FEC)	Annual completion and submission of Youth/Family Services Survey for Families (YSS-F) Experience of Care Survey, identifying results separately for BHCs and comparison clinics and oversampling those clinics.	SAMHSA	NA	NA	State	YSS-F Survey
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	The percentage of emergency department (ED) visits for consumers aged 6+ with a primary diagnosis of mental illness, who had an outpatient visit, an intensive outpatient encounter or a partial hospitalization for mental illness. Two rates are reported: (1) percentage of ED visits for which the consumer received a follow-up within 30 days of the ED visit; and (2) percentage of ED visits for which the consumer received a follow-up within seven days of the ED visit.	NCQA	NA	NA	State	Administrative

Title	Definition	Measure Steward	NQF	Required Bonus Measure	Collector	Collection Method
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)	The percentage of emergency department (ED) visits for consumers 13 years of age and older with a primary diagnosis of alcohol or other drug (AOD) dependence, who had an outpatient visit, an intensive outpatient encounter or a partial hospitalization for AOD. Two rates are reported: (1) percentage of ED visits for which the consumer received a follow-up within 30 days of the ED visit; and (2) percentage of ED visits for which the consumer received a follow-up within seven days of the ED visit.	NCQA	NA	NA	State	Administrative
Plan All-Cause Readmission Rate (PCR-BH)	For consumers aged 18+, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days. Data are reported in three categories: (1) count of index hospital stays (IHS) – denominator; (2) count of 30-day readmissions – numerator; and (3) readmission rate – numerator/denominator.	NCQA	1768	NA	State	Administrative
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD)	The percentage of consumers aged 18-64 with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	NCQA	1932	NA	State	Administrative
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-BH)	Percentage of consumers aged 19 to 64 during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.	NCQA (Originally based on HEDIS 2016)	NA	Yes	State	Administrative

Title	Definition	Measure Steward	NQF	Required Bonus Measure	Collector	Collection Method
Follow-Up After Hospitalization for Mental Illness (FUH-BH)	The percentage of discharges for consumers who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner (NOTE: metric is segmented by age into two groups: six - 21 and 21+). Two rates are reported: (1) percentage of ED visits for which the consumer received a follow-up within 30 days of the ED visit; and (2) percentage of ED visits for which the consumer received a follow-up within seven days of the ED visit.	NCQA	0576	Yes	State	Administrative
Follow-Up Care for Children Prescribed ADHD Medication (ADD-BH)	Percentage of children newly prescribed ADHD medication who had at least three follow-up care visits within a 10- month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported: (1) Initiation Phase: Percentage of children aged six to 12 as of the Index Prescription Start Date (ISPD) with an ambulatory prescription dispensed for ADMD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase; and (2) Continuation and Maintenance (C and M) Phase: Percentage of children aged six to 12 as of the Index Prescription Start Date (ISPD) with an ambulatory prescription dispensed for ADMD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, who had at least two follow-up visits with a practitioner within 270 days after the Initiation Phase ended.	NCQA	0108	No	State	Administrative

Title	Definition	Measure Steward	NQF	Required Bonus Measure	Collector	Collection Method
Antidepressant Medication Management (AMM-BH)	The percentage of consumers aged 18+ who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. Two rates are reported: (1) Effective Acute Phase Treatment – percentage of consumers who remained on an antidepressant medication for at least 84 days (12 weeks); and (2) Effective Continuation Phase Treatment – percentage of consumers who remained on an antidepressant medication for at least 180 days (six months).	NCQA	0105	No	State	Administrative
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-BH)	Percentage of consumers aged 13+ with a new episode of alcohol or other drug (AOD) dependence who received the following: (1) initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis; and (2) initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	NCQA	0004	Yes	State	Administrative