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State/Territory Name: NV

State Plan Amendment (SPA) #: 23-0002

This file contains the following documents in the order

listed: 1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
230 South Dearborn
Chicago, Illinois 60604

Financial Management Group

May 3, 2024

Stacie Weeks, Administrator
Nevada Division of Health Care Financing and Policy
1210 S. Valley View, Suite 105
Las Vegas, NV 89702

RE: TN 23-0002

Dear Administrator Weeks:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Nevada state plan amendment (SPA) to Attachment 4.19-B 23-0002, which was submitted to CMS on February 1, 2023. This plan amendment updates the updates the payment methodology for state plan Certified Community Behavioral Health Clinics (CCBHCs).

We reviewed your SPA submission for compliance with statutory requirements including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of May 12, 2023. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Blake Holt at 303-844-6218 or via email at blake.holt@cms.hhs.gov.

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 23 — 0002

2. STATE: NV

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
May 12 July 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION
State Plan Under Title XIX of the Social Security Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023 $ 1,071,070
b. FFY 2024 $ 4,079,454

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B Pages 9b-9d *and 9e*

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
4.19-B pages 8a-8d

9. SUBJECT OF AMENDMENT
Certified Community Behavioral Health Centers (CCBHCs) daily bundled rates year 1, 2, 3 and onward. Qualtiy Incentive Payment year 1, 2, 3 and onward.

10. GOVERNOR'S REVIEW *(Check One)*
( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, ASSPECIFIED:

11. SIGNATURE OF STATE OFFICIAL
[redacted]

12. TYPED NAME
RICHARD WHITLEY

13. TITLE
DIRECTOR, DHHS

14. DATE SUBMITTED
February 1, 2023

15. RETURN TO
Sandie Ruybalid, Deputy Administrator
DHCFP/Medicaid
1100 East William Street, Suite 101
Carson City, NV 89701

FOR CMS USE ONLY

16. DATE RECEIVED
February 1, 2023

17. DATE APPROVED
May 3, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
May 12, 2023

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Todd McMillion

21. TITLE OF APPROVING OFFICIAL
Director, Division of Reimbursement Review

22. REMARKS

6/9/23:State concurs with pen and ink change to Box 4.
4/24/24: state concurs with pen and ink change to Box 7.

Regarding Boxes 7 and 8: Note that this SPA deletes pages 8a-8d of the plan and move the content to new pages 9b-9e.

FORM CMS-179 (09/24)

Instructions on Back

Rehabilitative Services: Certified Community Behavioral Health Center (CCBHC)

The Medicaid program will provide coverage for a bundle of medically necessary rehabilitative services under "Service Array" in Attachment 3.1A provided by practitioners employed by, or associated with, provider entities to be known as Certified Community Behavioral Health Center (CCBHCs). CCBHCs are provider entities certified by the Nevada Department of Public and Behavioral Health (DPBH) as meeting the State's qualifications for a CCBHC.

Bundled daily rate for year one

Effective July 1, 2023, the State will use the average bundled daily rate of current CCBHCs to set first year bundled daily rates.

Rates following year one

A. Providers with an established rate on May 11, 2023

For providers who are past Year 1 and had an established rate on May 11, 2023, that rate will continue to be paid for services provided through June 30, 2023.

Effective July 1, 2023, and on July 1 for each of the following two fiscal years, these providers will have their rates updated annually by the Medicare Economic Index (MEI), as described in Paragraph C or through rebasing as described in Annual Updates to the Bundled Rate for CCBHC Services and Rebase of the Bundled Rate for CCBHC Services below.

B. Providers who Year 1 is established on or after July 1, 2023

Effective July 1, 2023, CCBHCs whose Year 1 rate is established on or after July 1, 2023, will be required to submit a cost report after Year 2 inclusive of a year of actual costs and visits for CCBHC services as described below. These CCBHC providers will continue to be reimbursed at the year one rate until the daily bundled rate based on actual Year 1 costs and visits can be calculated. Once the daily bundled rate has been calculated using actual costs on the CCBHC cost report submitted, the rate effective date will be aligned with the start date of the subsequent quarter. Any payments for services provided prior to this effective date will not be reconciled.

After the cost-based rate has been determined, these providers will have their rates updated annually by the Medicare Economic Index (MEI) or through rebasing as described in Annual Updates to the Bundled Rate for CCBHC Services and Rebase of the Bundled Rate for CCBHC Services below.

C. Annual Updates to the Bundled Rate for CCBHC Services

Effective July 1, 2023, and each consecutive July 1st (SFY) thereafter, provider's current rates will be adjusted to account for inflation, unless the provider's rate has been rebased on or after July 1 of the

preceding year. The rates are adjusted to account for inflation by trending them forward by the current Medicare Economic Index (MEI), as defined in Section 1842(i)(3) of the Social Security Act, to determine the subsequent bundled rate. Trending by the MEI is intended to account for the basic cost increases associated with providing such services.

D. Rebase of the Bundled Rate for CCBHC Services

Beginning January 1, 2025, bundled reimbursement rates for CCBHC services must be rebased once within each designated 5-year period. Providers may select any full fiscal year of services within each designated 5-year period for the rebase to occur; however, a provider may not rebase their rate more than once within each designated 5-year period. When a provider indicates they are requesting a rebase of their rate, the most recent full year of cost reporting data is utilized to determine the rebased rate; providers may not utilize an earlier cost report for the rebase. If a provider has not requested a rebase by the end of designated the 5-year period, their rate will be rebased based on the most recent full fiscal year of data and effective at the beginning of the next five-year period.

The first 5-year rebase period will extend from January 1, 2025, to December 31, 2029, with each subsequent 5-year rebase period following similar timelines. Year 2 rebasing per the methodology in Paragraph B above that occurs within a designated 5-year period would satisfy the requirements of this paragraph.

Rebased rates are effective at the beginning of the quarter following the approval of the calculated rebased rate.

Rate Rebasing and Cost Report Requirements

A provider's rate will be rebased automatically by the state at least every five years as described below using the most recent cost report that reflects the provider's fiscal year.

Cost reports will be used to calculate the bundled per visit rate for CCBHC services by dividing the total allowable costs of CCBHC services by the total number of CCBHC visits. Cost and visit data vary based on CCBHC size, location, economy, and scope of services offered and must adhere to 2 Code of Federal Regulations (CFR) Part 200 as implemented for HHS at 45 CFR Part 75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for the US Department of Health and Human Services (HHS) Awards. The CCBHC must submit all required documentation of actual costs for a full year of providing services to Division of Health Care Financing and Policy (DHCFP) no later than 90 calendar days or 3 months after a year of operations as a CCBHC.

E. Quality Incentive Payments and Data Requirements

All CCBHC practitioners are eligible for a Quality Incentive Payment (QIP) based on achieving specific numerical thresholds with regard to state mandated performance measures. The performance period shall be a state fiscal year (7/1-6/30). CCBHC practitioners will receive a QIP payment for each individual performance measure in which they achieve the threshold. A CCBHC will have met the particular

performance measure by meeting or exceeding the posted improvement target goal for the measure. If the State chooses a measure for which there is no improvement target goal, the CCBHC can achieve the threshold for that measure by meeting or exceeding statewide mean for the measure. Performance measures shall be calculated exclusively on the basis of data for Medicaid beneficiaries, excluding beneficiaries dually eligible for the Medicaid and Medicare programs.

Each CCBHC will be required to submit electronic health record (EHR) data to the State on a quarterly basis for calculation of the measures on an ongoing basis. CCBHCs that fail to submit all required data within six months following the end of each the performance year will not be eligible for a QIP. Final results of the performance of each CCBHC on the required measures will be posted by June 30 of each year on DHCFP website CCBHC pages and shared directly with each CCBHC.

DHCFP shall establish the minimum patient volume in each performance measure denominator necessary for the performance measure to be valid. Measures that do not meet the minimum patient threshold will not be eligible for payment under the QIP and no proportioned payment of that measure will be made. Measures that do not meet the minimum patient threshold will reduce the overall QIP percentage achievable by that provider. QIP payments are composed of two payments - a payment for reporting and a payment for performance. In the first two years, the QIP will only be comprised of the payment for reporting. The amount of QIP to a CCBHC will be based on multiplying the total facility-specific bundled rate payments made to the CCBHC in the performance period by a statewide percentage for reporting requirements in the first two years and by both a statewide percentage for performance requirements and a statewide percentage for reporting requirements in subsequent years.

QIP for Reporting

In years one and two, a 10% QIP is issued for submitting the full and complete required datasets for all measures, set in the technical specifications. Data must be reported for the entire performance period in which the provider is enrolled as a CCBHC.

In year three and subsequent years, a 5% QIP will be issued if the full and complete required datasets for all measures are submitted for the entire performance period.

The QIP reporting amount for a CCBHC will be calculated by multiplying the total facility-specific bundled rate payments made to the CCBHC in the performance period by the 10% statewide percentage for reporting requirements in the first two years and by the 5% statewide percentage for reporting requirements in subsequent years.

QIP for performance

Beginning in year 3 and subsequent years, an additional 10% can be added to the QIP for reporting payment based on performance.

- This performance QIP is broken down into:
    - 1% payment for attainment each of the six required measures with an additional 2% payment for attaining performance for Plan All-Cause Readmission measure

- 2% payment for attaining the State directed crisis measure.

The QIP for performance is calculated by taking the sum of the total facility-specific bundled rate payments made to the CCBHC in the performance period multiplied by 1% for each of the six required measures attained plus 2% of those total facility payments if the Plan All-Cause Readmission measure and 2% for the State directed crisis measure when attained.

Data Submission Requirements:

All Data is required to be submitted quarterly.

- Data from Medicaid and non-Medicaid CCBHC recipients.
- Submissions are due to DHCFP no later than 30 days after the end of the previous quarter.

QIPs will be made to CCBHCs meeting the above criteria in a lump sum payment, within one year following the end of the relevant measurement year (July 1 to June 30), and after all final data needed to calculate the QIP is received.

QIP performance measures, patient volume minimums and target numerical thresholds for each measure are effective July 1, 2023, and are located at https://dhcfp.nv.gov/Pgms/CCBHC/CCBHC_Main_NEW/. QIP performance measure technical specifications submitted to CMS in June of 2023 as a part of the review process of SPA NV-23-0002 are effective July 1, 2023.