

## **Table of Contents**

**State/Territory Name: Nevada**

**State Plan Amendment (SPA) #: 19-0010**

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  
601 East 12th Street, Suite 0300  
Kansas City, Missouri 64106-2898



Medicaid and CHIP Operations Group

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March 4, 2020

Suzanne Bierman, Administrator  
Nevada Division of Health Care Financing and Policy  
1210 S. Valley View, Suite 104  
Las Vegas, NV 89702

Dear Ms. Bierman:

Enclosed is an approved copy of Nevada State Plan Amendment (SPA) 19-010. The state plan amendment establishes services and a reimbursement methodology for Certified Community Behavioral Health Clinics (CCBHCs) in the state plan. This SPA is approved on March 4, 2020, with an effective date of August 1, 2019.

Attached is a copy of the following approved pages to be incorporated into your state plan:

- Attachment 3.1-A, Page 6c
- Attachment 4.19-B, Pages 8a, 8b, 8c, and 8d

If you have any questions, please contact Peter Banks by phone at (415) 744-3782 or by email at [Peter.Banks@cms.hhs.gov](mailto:Peter.Banks@cms.hhs.gov).

Sincerely,

A solid black rectangular box redacting the signature of James G. Scott.

James G. Scott, Director  
Division of Program Operations

Enclosure

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b> <b>FOR: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>	1. TRANSMITTAL NUMBER <u>1 9 - 0 1 0</u>	2. STATE NEVADA
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SSA (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. <b>PROPOSED EFFECTIVE DATE</b> [REDACTED] August 1, 2019	

5. TYPE OF PLAN MATERIAL (Check One)

NEW STATE PLAN       AMENDMENT TO BE CONSIDERED AS NEW PLAN       AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate transmittal for each amendment)

6. <b>FEDERAL STATUTE/REGULATION CITATION</b> 42 CFR 447, 431 Subpart M	7. <b>FEDERAL BUDGET IMPACT</b> a. FFY 2020 \$ <u>9,023,164.16</u> b. FFY 2021 \$ <u>14,809,737.94</u>
8. <b>PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT</b> [REDACTED] Attachment 3.1-A, Page 6c Attachment 4.19-B, Pages 8a, 8b, 8c, and 8d	9. <b>PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)</b> [REDACTED] Attachment 3.1-A, Page 6c

10. **SUBJECT OF AMENDMENT**

This State Plan Amendment (SPA) adds Certified Community Behavioral Health Clinics (CCBHC) services. ■

11. GOVERNOR'S REVIEW (Check One)

GOVERNOR'S OFFICE REPORTED NO COMMENT       OTHER, AS SPECIFIED  
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL [REDACTED]	16. RETURN TO Tammy Moffitt, Chief of Operations DHCFP/Medicaid 1100 East William Street, Suite 101 Carson City, NV 89701
13. TYPED NAME STEVE SISOLAK	
14. TITLE GOVERNOR, STATE OF NEVADA	
15. DATE SUBMITTED 8/28/19	

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED 8/28/19	18. DATE APPROVED March 4, 2020
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**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL 8/1/19	20. SIGNATURE OF REGIONAL OFFICIAL [REDACTED]
21. TYPED NAME James G. Scott	22. TITLE Director, Division of Program Operations

23. REMARKS

Pen and Ink Request: Box 4: Update to "August 1, 2019". Box 8: Update to "Attachment 3.1-A, Page 6c / Attachment 4.19-B, Pages 8a, 8b, 8c, and 8d". Box 9: Update to "Attachment 3.1-A, Page 6c". Box 10: Update to "This State Plan Amendment (SPA) adds Certified Community Behavioral Health Clinics (CCBHC) services.". Box 15: Update to "8/28/19".

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

Attachment 3.1-A

Page 6c

### Certified Community Behavioral Health Centers (CCBHC)

Certified Community Behavioral Health Center (CCBHC) is an entity that provides integrated, comprehensive health services with a focus on behavioral health. Certification indicates that the entity meets criteria as established by the State of Nevada, by the Division of Public and Behavioral Health's (DPBH) Health Care Quality and Compliance (HCQC) bureau. CCBHC's services must be provided under the philosophy of recovery and be informed by best practices for working with individuals from diverse cultural and linguistic backgrounds. Providers within the CCBHC model utilize pre-existing provider qualifications outlined under the current Rehabilitative section of the State Plan for behavioral health services and HCQC validates the appropriate policies and procedures are in place to operate as a CCBHC.

CCBHCs may also contract with Designated Collaborative Organization (DCO) that provide aspects of those services. Designated Collaborating Organization (DCO) is a distinct entity that is not under the direct supervision of a CCBHC but has a formal contractual relationship with a CCBHC to provide an authorized CCBHC service. The CCBHC must ensure the DCO provides the same quality of care as those required by the CCBHC certification. The CCBHC maintains ultimate clinical responsibility for the services provided to CCBHC recipients by the DCO under this agreement. To the extent that services are required that cannot be provided by either the CCBHC directly or by a DCO, referrals may be made to other providers or entities. The CCBHC retains responsibility for the overall coordination of a recipient's care including services provided by the DCO or those to which it refers a recipient. Providers within the DCO's utilize pre-existing provider qualifications outlined in the State Plan.

### Service Array:

Nevada Medicaid offers the following services under a CCBHC delivery model. The services are currently covered services under the Rehabilitative Services benefit (13d.) of the State Plan.

- Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services and crisis stabilization;
- Screening, assessment and diagnosis, including risk assessment;
- Patient-centered treatment planning or similar processes, including risk assessment and crisis planning;
- Outpatient mental health and substance use services;
- Outpatient clinic primary care screening and monitoring of key health indicators and health risk; targeted case management;
- Psychiatric rehabilitation services;
- Peer support and counselor services and family supports.

### Service Limitations:

There are no limitations on the amount, duration, and scope for services furnished under a CCBHC delivery model. An individual's treatment plan defines the services they will receive.

### Practitioner/Provider Qualifications:

Please refer to the chart located at the beginning of the 13d. Rehabilitative Service section.

TN No.: 19-010

Approval Date: March 4, 2020

Effective Date: August 1, 2019

Supersedes

TN No.: 08-009

**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.

The State agency will reimburse CCBHC practitioners a facility-specific bundled daily rate applicable to providers affiliated with CCBHCs.

These cost-based rates reflect the center’s unique costs and they ensure that CCBHCs receive at least their costs for providing services to Medicaid members. Payments will be limited to one payment per day, per recipient, regardless of the number of services received within a single day by center users accessing services from CCBHC practitioners. Encounters with more than one health practitioner and multiple encounters with the same health practitioner that take place on the same day and that share the same or like diagnoses constitute a single billable encounter. This also applies to encounters with multiple CCBHC providers in the same day. Only providers affiliated with the CCBHC who are designated as the principle behavioral health provider and holds the plan of care, will be issued a facility-specific bundled daily rate.

The CCBHC bundled daily reimbursement methodology is effective for services provided on and after August 1, 2019.

**Interim bundled daily rate for year one (new facilities without an established rate)**

The State will allow the use of anticipated allowable costs to determine first year bundled daily rates. To determine the interim bundled daily rate for the first year of CCBHC operations, the State will:

- Utilize the CCBHC Cost Report as reviewed by the Centers for Medicare and Medicaid Services (CMS) to calculate the bundled per visit rate by dividing total allowable anticipated CCBHC services by total anticipated CCBHC visits.
- Allowable CCBHC cost include total direct cost of CCBHC services plus indirect cost applicable to CCBHC services.
  - Direct CCBHC cost include the actual salaries and benefits of Medicaid qualified providers, costs of services provided under agreement, and other direct CCBHC costs such as medical supplies or professional liability insurance specific to the CCBHC program. The CCBHC will also be required to identify the costs of providing “non-CCBHC services,” so that related indirect costs can be excluded from the rate. Examples of “non-CCBHC” services that a community behavioral health provider might provide include psychiatric residential treatment programs and habilitative services for developmentally disabled individuals.

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEVADA

Attachment 4.19-B

Page 8b

- Indirect costs include site and administrative costs associated with providing all clinic services, including both CCBHC and non-CCBHC services. Indirect costs are allocated based on a pro-rated share of CCBHC costs to non-CCBHC costs.
- Total CCBHC visits include all visits for CCBHC services, including both Medicaid and non-Medicaid visits. A CCBHC “visit” or an “encounter” for the purposes of reimbursing CCBHC services is defined as face-to-face contact with one or more qualified health professionals that take place on the same day with the same patient.

### Reconciliation of bundled daily rate following year one

After the first year of operation, the CCBHC will be required to submit a cost report inclusive of all actual costs to provide services for the first year of operations to calculate the bundled per visit rate by dividing total allowable CCBHC services by total CCBHC visits. Cost and visit data vary based on CCBHC size, location, economy, and scope of services offered and must adhere to 45 Code of Federal Regulations (CFR) 75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for the US Department of Health and Human Services (HHS) Awards and 42 CFR 413 Principles of Reasonable Cost Reimbursement. The CCBHC must submit all required documentation of actual costs for the first full year of providing services to Division of Health Care Financing and Policy (DHCFP) no later than 150 calendar days or 5 months after the first year of operations as a CCBHC. DHCFP will deem cost reports complete within 15 days of receipt. CCBHCs with missing documentation will be issued a cost report request letter, identifying missing documentation necessary to complete the cost report. The CCBHC will have 30 days from the date of the cost report request letter to submit additional documentation. If a CCBHC does not submit the required documentation to complete their cost report within 30 days, DHCFP reserves the right to suspend their Medicaid payments or require the CCBHC to pay back state Medicaid program payments received during the fiscal year period for which they were to provide a complete cost report. This process will remain in effect until the CCBHC has provided a complete cost report.

The DHCFP will conduct an annual settlement based on the difference in the anticipated costs used to inform the interim year one rate and the actual year one costs as determined by the cost report. The settlement will apply to all claims from the first day of services until the day the new rate is determined, which could result in a payout or a recoupment. CCBHCs will continue to be reimbursed at the year one rate until the determination of payment or recoupment is determined and the final bundled daily rate is calculated. Reconciliation will be completed within 18 months of deeming the cost report complete.

### Bundled daily rate for year two

Once the daily bundled rate has been calculated using actual costs on the CCBHC cost report submitted after the end of year one, the rate effective date will be aligned with the start date of year two.

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TN No.: 19-010

Approval Date: March 4, 2020

Effective Date: August 1, 2019

Supersedes

TN No.: NEW

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEVADA

Attachment 4.19-B

Page 8c

Bundled daily rate for year three onward

Thereafter, for each consecutive year on July 1st (SFY) the bundled daily rate will be trended by the current Medicare Economic Index (MEI) for primary care services as defined in Section 1842(i)(3) of the Social Security Act, which is intended to account for the basic cost increases associated with providing such services.

Bundled daily rates will not be subject to rebasing after the year 2 rate is set.

**Quality Incentive Payments**

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). The eligibility of each CCBHC practitioner to receive a QIP is judged independently; and in order for a provider to receive a QIP, the CCBHC must achieve the thresholds on all of state mandated performance measures. 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 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 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 DPBH website CCBHC pages and shared directly with each CCBHC.

DPBH shall establish the minimum patient volume in each performance measure denominator necessary for the performance measure to be valid. 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 not to exceed 10% based on pay for reporting requirements in the first year and 15% in each consecutive year based on pay for performance and pay for reporting requirements.

In the first year a 10% QIP is issued for submitting the required datasets, if a full year is reported. For a CCBHC practitioner who comes online partially through a fiscal year and a full year of data is not submitted, then a prorated amount will be paid for each month reported. For example, a CCBHC practitioner who came online effective January 1 would be eligible for 50% of the payment they would otherwise be eligible for the entire year.

In the second and subsequent years a 5% QIP will be issued if the required datasets are submitted. An additional 10% can be added to this payment and is broken down into 8.5% payment for attaining performance on all 6 required measures with another possible 1.5% payment for attaining performance for 1 optional measure (Plan All-Cause Readmission Rate).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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TN No.: 19-010

Approval Date: March 4, 2020

Effective Date: August 1, 2019

Supersedes

TN No.: NEW

When applicable, QIPs will be made in a lump sum payment, within 1 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.

The state mandated QIP performance measures, technical specifications, patient volume minimums and target numerical thresholds for each measure are effective August 1, 2019 and are located at <http://dpbh.nv.gov/Reg/CCBHC/CCBHC-Main/>.