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 ~~of anticipated allowable costs~~the average bundled daily rate of current CCBHCs to ~~determine~~ set 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.~~

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- ~~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 lability 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.~~

- ~~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~~ Effective period of bundled daily rate following year one:

After the first full 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 or requested fiscal year as approved by DHCFP. This cost report will be used 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~~ 90 calendar days or ~~5~~ 3 months after the first year of operations as a CCBHC. DHCFP will deem cost reports complete within ~~15~~ 30 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~~ 15 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~~ 15 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. Failure to comply with the cost reporting process within 150 calendar days of the end of the first full year of operations will result in disenrollment with DHCFP. If a provider has been disenrolled from DHCFP the provider will not be eligible to reenroll as a CCBHC for 2 full calendar years after the disenrollment date.

~~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 actual costs can be calculated. ~~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.~~ These rates will be entered in prospectively into Medicaid Management

Information System (MMIS).

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 or requested fiscal year as approved by DHCFP, the rate effective date will be aligned with the start date of ~~year two~~subsequent State Fiscal Year.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Bundled daily rate for year three onward

Thereafter, for each consecutive year on July 1st (SFY) the bundled daily rate will be ~~trended~~ adjusted by either of the following:

- ~~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 or, ~~.~~
- Rebasing by the provider submitting a cost report for the requested fiscal year.

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

The rebasing process will ~~mirror~~ replicate the process under reconciliation of bundled daily rate following year one. Rebasing may not occur more frequently than every five (5) years.

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). 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 (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 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~~ DHCFP website CCBHC pages and shared directly with each CCBHC.

~~DPBH~~ DHCFP 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~~year one a 10% QIP is issued for submitting the full and complete required datasets, set in the technical specifications, if data for the period ~~a full year~~ is reported. Year one begins on July 1 within the first year of enrollment with DHCFP. ~~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~~year two and subsequent years a 5% QIP will be issued if the full and complete required datasets are submitted.

An additional 10% can be added to this payment and is broken down into ~~8.5~~1% payments for ~~attaining performance on all~~attaining each of the individual 6 required measures with ~~another~~ an additional ~~possible 1.5~~2% payment for attaining performance for 1 optional measure (Plan All-Cause Readmission Rate). An additional 2% payment for attaining the State directed crisis measure.

Data Submission Requirements:

All Data is required to be submitted quarterly.

- Data from non-Medicaid CCBHC recipients.
- Quarterly submission of CCBHC documented growth of the recipients. It is expected CCBHCs will show growth and initiative to providing services to new recipients each State Fiscal Year.
- Submissions are due to DHCFP no later than 30 days after the end of the previous quarter.

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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~~July 1, 2023 and are located at https://dhcfp.nv.gov/Pgms/CCBHC/CCBHC_Main_NEW/ ~~http://dpbh.nv.gov/Reg/CCBHC/CCBHC-Main/~~.

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