TITLE 1 ADMINISTRATION
PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 353 MEDICAID MANAGED CARE
SUBCHAPTER O DELIVERY SYSTEM AND PROVIDER PAYMENT INITIATIVES

ADOPTION PREAMBLE

The Texas Health and Human Services Commission (HHSC) adopts an amendment to §353.1320, concerning the Directed Payment Program for Behavioral Health Services.

The amendment to §353.1320 is adopted with changes to the proposed text as published in the November 17, 2023, issue of the *Texas Register* (48 TexReg 6691). This rule will be republished.

BACKGROUND AND JUSTIFICATION

The purpose of the amendment is to pursue modifications to the Directed Payment Program for Behavioral Health Services (DPP BHS) to simplify the program structure, provide additional details concerning certain enrollment-related processes and procedures, and reduce the administrative burden of operating the program for HHSC and participating providers.

HHSC sought and received authorization from the Centers for Medicare and Medicaid Services to create DPP BHS for state fiscal year 2022 as part of the financial and quality transition from the Delivery System Reform Incentive Payment program. HHSC has not made significant modifications to DPP BHS since its inception in state fiscal year 2022.

Directed payment programs authorized under 42 C.F.R. §438.6(c), including DPP BHS, are expected to continue to evolve over time so that the program can continue to advance the quality goal or objective the program is intended to impact.

HHSC has determined that DPP BHS contains certain provisions that pose administrative complexity that may impede HHSC's and the participating providers' ability to use the program to advance a quality goal or strategy. HHSC, therefore, amends and modifies the program rule to reduce administrative complexity and burden for participants.

The rule amendment also consolidates DPP BHS into a single component to be paid via a scorecard, Component One only, for state fiscal year 2025 and after, so all payments will be paid by managed care organizations (MCOs) as a lump sum payment based on a scorecard issued by HHSC. This rule amendment reduces the administrative burden on providers and MCOs, as the payments will no longer be made via the claim adjudication process and will be exclusively made via the monthly scorecard outside of the claims process.

HHSC is changing the eligible provider classes to only have one eligible provider class now that all participating providers have achieved a Certified Community Behavioral Health Clinic (CCBHC) certification.

HHSC will determine the network status of an enrolling provider for an entire program period based on the submission of supporting documentation through the enrollment process.

HHSC included other minor clarifying or grammatical revisions to improve the readability of the rule text.

COMMENTS

The 31-day comment period ended December 18, 2023.

During this period, HHSC received feedback regarding the proposed rule amendment from two commenters, including the Texas Council of Community Centers and My Health My Resources of Tarrant County.

Comment: One commenter supports combining all funding into Component One and requiring participants to be CCBHC certified. They also support the new process to verify network status and would like more details about the process and responsibilities of providers and MCOs. They suggest continued consideration of the option to add CCBHC codes to the Medicaid fee schedule and eliminate the program.

Response: HHSC acknowledges the comment. HHSC is committed to allowing reasonable, flexible options for MCOs to verify network status and will keep the option of implementing CCBHC billing codes open for future consideration. No revision to the rule text was made in response to this comment.

Comment: One commenter supports changes to the payment structure but encourages HHSC to explore the use of CCBHC billing codes and a payment structure similar to Demonstration states, believing these actions will ease the transition to Demonstration and that use of standard CCBHC codes will assist the commenter's agency in using their electronic health record.

Response: HHSC acknowledges the comment. HHSC will keep the options of implementing CCBHC billing codes, as well as aligning to the payment structure of other states, open for future consideration. No revision to the rule text was made in response to this comment.

A minor editorial change was made to §353.1320(e)(1)(A) inserting "program" after "the" to clarify that participants may not join the program after the enrollment period closes.

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.033, which provides the Executive Commissioner with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; Texas Government Code §531.021(b-1), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for medical assistance payments under the Texas Human Resources Code Chapter 32; and Texas Government Code §533.002, which authorizes HHSC to implement the Medicaid managed care program.

The amendment implements Texas Government Code Chapter 531, Texas Government Code, Chapter 533, and Texas Human Resources Code Chapter 32.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

ADDITIONAL INFORMATION

For further information, please call 512-707-6071.

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PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 353 MEDICAID MANAGED CARE
SUBCHAPTER O DELIVERY SYSTEM AND PROVIDER PAYMENT INITIATIVES

§353.1320. Directed Payment Program for Behavioral Health Services.

(a) Introduction. This section establishes the Directed Payment Program for Behavioral Health Services (DPP BHS). DPP BHS is designed to incentivize behavioral health providers to improve quality, access, and innovation in the provision of medical and behavioral health services to Medicaid recipients through the use of metrics that are expected to advance at least one of the goals and objectives of the state's managed care quality strategy.

(b) Definitions. The following definitions apply when the terms are used in this section. Terms that are used in this section may be defined in §353.1301 of this subchapter (relating to General Provisions) or §353.1322 of this subchapter (relating to Quality Metrics for the Directed Payment Program for Behavioral Health Services).

(1) Average Commercial Reimbursement (ACR) gap--The difference between what an average commercial payor is estimated to pay for the services and what Medicaid actually paid for the same services.

(2) Certified Community Behavioral Health Clinic (CCBHC)--A clinic certified by the state in accordance with federal criteria and with the requirements of the Protecting Access to Medicare Act of 2014 (PAMA).

(3) CCBHC cost-reporting gap--The difference between what Medicaid pays for services and what the reimbursement would be based on the CCBHC cost-reporting methodology.

(4) Community Mental Health Center (CMHC)--An entity that is established under Texas Health and Safety Code §534.0015 and that:

(A) Provides outpatient services, including specialized outpatient services for children, the elderly, individuals with serious mental illness, and residents of its mental health service area who have been discharged from inpatient treatment at a mental health facility.

(B) Provides 24-hour-a-day emergency care services.

(C) Provides day treatment or other partial hospitalization services, or psychosocial rehabilitation services.

(D) Provides screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission.

(5) Intergovernmental transfer (IGT) notification--Notice and directions regarding how and when IGTs should be made in support of DPP BHS.

(6) Local Behavioral Health Authority (LBHA)--An entity that is designated under Texas Health and Safety Code §533.0356.

(7) Program period--A period of time for which the Texas Health and Human Services (HHSC) contracts with participating managed care organizations (MCOs) to pay increased capitation rates for the purpose of provider payments under this section. Each program period is equal to a state fiscal year beginning September 1 and ending August 31 of the following year.

(8) Providers--For program periods on or before August 31, 2022, an entity described in paragraph (4) of this subsection. For program periods on or after September 1, 2022, an entity described in paragraph (4) or (6) of this subsection.

(9) Suggested IGT responsibility--Notice of potential amounts that a sponsoring governmental entity may wish to consider transferring in support of DPP BHS.

(10) Total program value--The maximum amount available under the Directed Payment Program for Behavioral Health Services for a program period, as determined by HHSC.

(c) Classes of participating providers.

(1) HHSC may direct the MCOs to provide a uniform percentage rate increase or a uniform dollar increase to all providers within one or more of the following classes of providers with which the MCO contracts for services:

(A) For program periods beginning on or before September 1, 2023, providers that are certified CCBHCs and providers that are not certified CCBHCs.

(B) For program periods beginning on or after September 1, 2024, providers who are certified CCBHCs.

(2) If HHSC directs rate or dollar increases to more than one class of providers within the service delivery area, the rate or dollar increases directed by HHSC may vary between classes.

(d) Data sources for historical units of service. Historical units of service are used to determine a provider's eligibility status to receive the estimated distribution of program funds across enrolled providers.

(1) HHSC will use encounter data and will identify encounters based upon the billing provider's national provider identification (NPI) number.

(2) The most recently available Medicaid encounter data for a complete state fiscal year will be used to determine the distribution of program funds across eligible and enrolled providers.

(3) In the event that the historical data are not deemed appropriate for use by actuarial standards, HHSC may use data from a different state fiscal year at the discretion of the HHSC actuaries.

(4) The data used to estimate the distribution of funds will align to the extent possible with the data used for purposes of setting the capitation rates for MCOs for the same period.

(5) HHSC will calculate the estimated rate that an average commercial payor or Medicare would have paid for similar services or based on the CMS-approved CCBHC cost report rate methodology using either data from Medicare cost reports or collected from providers.

(6) Encounter data used to calculate DPP BHS payments must be designated as paid status with a reported paid amount greater than zero. Encounters reported as paid status, but with a reported paid amount of zero or negative dollars, will be excluded from the data used to calculate DPP BHS payments.

(e) Conditions of Participation. As a condition of participation, all providers participating in the program must allow for the following.

(1) The provider must submit a properly completed enrollment application by the due date determined by HHSC. The enrollment period must be no less than 21 calendar days, and the final date of the enrollment period will be at least nine calendar days prior to the release of suggested IGT responsibilities.

(A) Enrollment is conducted annually and participants may not join the program after the enrollment period closes. Any updates to enrollment information must be submitted prior to the publication of the IGT suggestion under subsection (j)(1) of this section.

(B) Network status for providers for the entire program period will be determined at the time of enrollment based on the submission of documentation through the enrollment process that shows an MCO has identified the provider as having a network agreement.

(2) The entity that bills on behalf of the provider must certify, on a form prescribed by HHSC, that no part of any payment made under the program will be used to pay a contingent fee and that the entity's agreement with the provider does not use a reimbursement methodology that contains any type of incentive, directly or indirectly, for inappropriately inflating, in any way, claims billed to the Medicaid program, including the provider's receipt of program funds. The certification must be received by HHSC with the enrollment application described in paragraph (1) of this subsection.

(3) If a provider contracts with another entity to provide DPP BHS-eligible services on behalf of the provider, the provider must submit all claims to the MCO using an NPI assigned to the provider as the billing provider's NPI.

(4) If a provider has changed ownership in the past five years in a way that impacts eligibility for DPP BHS, the provider must submit to HHSC, upon demand, copies of contracts it has with third parties with respect to the transfer of ownership or the management of the provider and which reference the administration of, or payment from, DPP BHS.

(5) Report all quality data denoted as required as a condition of participation in subsection (h) of this section.

(6) Failure to meet any conditions of participation described in this section will result in removal of the provider from the program and recoupment of all funds previously paid during the program period.

(f) Determination of percentage of rate and dollar increase.

(1) HHSC will determine the percentage of rate or dollar increase applicable to providers by program component.

(2) HHSC will consider the following factors when determining the rate increase:

(A) the estimated Medicare gap for providers, based upon the upper payment limit demonstration most recently submitted by HHSC to the Centers for Medicare and Medicaid Services (CMS);

(B) the estimated Average Commercial Reimbursement (ACR) gap for the class or individual providers, as indicated in data collected from providers;

(C) the estimated gap for providers, based on the CCBHC cost-reporting methodology that is consistent with the CMS guidelines;

(D) the percentage of Medicaid costs incurred by providers in providing care to Medicaid managed care clients that are reimbursed by Medicaid MCOs prior to any rate increase administered under this section; and

(E) the actuarial soundness of the capitation payment needed to support the rate increase.

(g) Services subject to rate and dollar increase. HHSC may direct the MCOs to increase rates or dollar amounts for all or a subset of provider services.

(h) Program capitation rate components. Program funds will be paid to MCOs through the managed care per member per month (PMPM) capitation rates. The MCOs' distribution of program funds to the enrolled providers will be based on each provider's performance related to the quality metrics as described in §353.1322 of this subchapter. The provider must have provided at least one Medicaid service to a Medicaid managed care client for each reporting period to be eligible for payments.

(1) Component One.

(A) The total value of Component One will be equal to 65 percent of the total program value for program periods beginning on or before September 1, 2023. For program periods beginning on or after September 1, 2024, Component One will be 100 percent of the total program value.

(B) Allocation of funds across all qualifying providers will be proportional, based upon historical Medicaid utilization.

(C) Monthly payments to providers will be a uniform rate increase.

(D) The interim allocation of funds across qualifying providers will be reconciled to the actual Medicaid utilization across these providers during the program period, as captured by Medicaid MCOs contracted with HHSC for managed care 120 days after the last day of the program period.

(i) Redistribution resulting from the reconciliation will be based on actual utilization of enrolled NPIs.

(ii) If a provider eligible for DPP BHS payments was not included in the monthly scorecards, the provider may be included in the reconciliation by HHSC.

(E) Providers must report quality data as described in §353.1322 of this subchapter as a condition of participation in the program.

(2) Component Two.

(A) The total value of Component Two will be equal to 35 percent of the total program value program periods beginning on or before September 1, 2023. For program periods beginning on or after September 1, 2024, the total value of Component Two will be equal to 0 percent of the total program value.

(B) Allocation of funds across all qualifying providers will be based upon historical Medicaid utilization.

(C) Payments to providers will be a uniform rate increase.

(D) Providers must report quality data as described in §353.1322 of this subchapter as a condition of participation in the program.

(i) Distribution of the Directed Payment Program for Behavioral Health Services payments.

(1) Prior to the beginning of the program period, HHSC will calculate the portion of each payment associated with each enrolled provider broken down by program capitation rate component and payment period. The model for scorecard payments and the reconciliation calculations will be based on the enrolled NPIs and the MCO network status at the time of the application under subsection (e)(1) of this section. For example, for a provider, HHSC will calculate the portion of each payment associated with that provider that would be paid from the MCO to the provider as follows.

(A) Monthly payments in the form of a uniform dollar increase for Component One will be equal to the total value of Component One attributed based upon historical utilization of the provider divided by twelve. An annual reconciliation will be performed for each provider based on actual utilization.

(B) For program periods beginning on or before September 1, 2023, rate increases from Component Two will be a uniform percentage rate increase on applicable services calculated based on the total value of Component Two for the providers divided by historical utilization of the respective services.

(C) For purposes of the calculation described in subparagraph (B) of this paragraph, a provider must achieve a minimum number of measures as identified in §353.1322 of this subchapter to be eligible for full payment.

(2) MCOs will distribute payments to enrolled providers based on criteria established under paragraph (1) of this subsection.

(j) Non-federal share of DPP BHS payments. The non-federal share of all DPP BHS payments is funded through IGTs from sponsoring governmental entities. No state general revenue that is not otherwise available to providers is available to support DPP BHS.

(1) HHSC will communicate suggested IGT responsibilities for the program period with all DPP BHS eligible and enrolled providers at least 10 calendar days prior to the IGT declaration of intent deadline. Suggested IGT responsibilities will be based on the maximum dollars available under DPP BHS for the program period as determined by HHSC, plus 10 percent; forecasted member months for the program period as determined by HHSC; and the distribution of historical Medicaid utilization across providers, for the program period. HHSC will also communicate estimated maximum revenues each eligible and enrolled provider could earn under DPP BHS for the program period with those estimates based on HHSC's suggested IGT responsibilities and an assumption that all enrolled providers will meet 100 percent of their quality metrics.

(2) Sponsoring governmental entities will determine the amount of IGT they intend to transfer to HHSC for the entire program period and provide a declaration of intent to HHSC 21 business days before the first half of the IGT amount is transferred to HHSC.

(A) The declaration of intent is a form prescribed by HHSC that includes the total amount of IGT the sponsoring governmental entity intends to transfer to HHSC.

(B) The declaration of intent is certified to the best knowledge and belief of a person legally authorized to sign for the sponsoring governmental entity but does not bind the sponsoring governmental entity to transfer IGT.

(3) HHSC will issue an IGT notification to specify the date that IGT is requested to be transferred no fewer than 14 business days before IGT transfers are due. HHSC will instruct sponsoring governmental entities as to the IGT amounts necessary to fund the program at estimated levels. IGT amounts will include the non-federal share of all costs associated with the provider rate increase, including costs associated with MCO (Capitation) premium taxes, risk margin, and administration, plus 10 percent.

(4) Sponsoring governmental entities will transfer the first half of the IGT amount by a date determined by HHSC, but no later than June 1. Sponsoring governmental entities will transfer the second half of the IGT amount by a date determined by HHSC, but no later than December 1. HHSC will publish the IGT deadlines and all associated dates on its Internet website by March 15 of each year.

(k) Effective date of rate and dollar reimbursement increases. HHSC will direct MCOs to increase reimbursements under this section beginning the first day of the program period that includes the increased capitation rates paid by HHSC to each MCO pursuant to the contract between them.

(l) Changes in operation. If an enrolled provider closes voluntarily or ceases to provide Medicaid services, the provider must notify the HHSC Provider Finance Department by electronic mail to an address designated by HHSC, by hand delivery, United States (U.S.) mail, or special mail delivery within 10 business days of closing or ceasing to provide Medicaid services. Notification is considered to have occurred when HHSC Provider Finance Department receives the notice.

(m) Reconciliation. HHSC will reconcile the amount of the non-federal funds actually expended under this section during each program period with the amount of funds transferred to HHSC by the sponsoring governmental entities for that same period using the methodology described in §353.1301(g) of this subchapter.

(n) Recoupment. Payments under this section may be subject to recoupment as described in §353.1301(j) - (k) of this subchapter.