Attachment C – DPP BHS Question 19 a, b, c and d.

19. If the State is seeking prior approval for a uniform dollar or percentage increase (option c in Question 16), please address the following questions:

a. Will the state require plans to pay a X uniform dollar amount or a X uniform percentage increase?

The state is selecting both boxes: a uniform dollar amount and a uniform percentage increase. The state is utilizing different payment requirements for the respective components of the program. The uniform dollar amount in Component 1 is intended to function as a prospective payment in a similar fashion to the Certified Community Behavioral Health Center (CCBHC) model Prospective Payment System-2 (monthly) (PPS-2) Rate. The uniform rate increase in Component 2 will be applied specifically to the top 20 CCBHC codes.

b. What is the magnitude of the increase (e.g., $4 per claim or 3% increase per claim?)

Component 1: $24.49 per unit;
Component 2: ~~52.19~~549.48% per claim for Community Mental Health Centers (CMHCs) and Local Behavioral Health Authorities (LBHAs) without CCBHC certification status
~~47.19~~594.48% per claim for CMHCs and LBHAs that are CCBHC certified.

c. Describe how will the uniform increase be paid out by plans (e.g., upon processing the initial claim, a retroactive adjustment done one month after the end of quarter for those claims incurred during that quarter).

A. Component 1 (65% of total program value; up to $154.8 million) under this preprint will be a uniform dollar increase. All CMHC and LBHA providers, with and without CCBHC certification status, will receive a uniform dollar increase for the top 20 procedure codes. Payments will be based on adjusted SFY20 (March 1, 2019 – February 29, 2020) units and will be paid prospectively on a monthly basis (equal to 1/12 of the annual amount) based on the historical utilization of the codes from the same SFY20, and trended forward with anticipated membership growth to SFY23. An annual reconciliation will be calculated for individual providers to align payments with actual SFY23 utilization at the end of the program period. The top 20 procedure codes were determined using adjusted SFY20 MCO claims payments for the STAR/STAR+PLUS/STAR Kids programs.

   A uniform dollar increase of $24.49 will be added to the top 20 procedure codes described above (See Attachment D for a listing of the top 20 codes).

   The $24.49 uniform dollar increase was calculated by dividing the SFY23 projected billable units into the $154.8 million available funds. The top 20 codes were analyzed based on service acuity and billable time components to establish a uniform billable unit of measure [analogous to Resource based relative value scale (RBRVS) reimbursement methodology]. The analysis established a fifteen-minute billable unit of measure. The billable unit of measure was developed by juxtaposing MCO paid units and defined service minutes. All codes demonstrated congruence with this method except these three:

   1. 90839, Psychotherapy For Crisis; First 60 Minutes
   2. 92523, Speech Sound Production And Language Evaluation
   3. H0005, Alcohol And/Or Drug Services; Group Counseling By A Clinician With (Hf) Substance Abuse Program

   Reasonable billable units were developed for these three codes after additional review. The

aforementioned procedure codes were adjusted to the fifteen-minute increment standard by increasing or decreasing their billable units based on individual work components, Medicaid/NCCI Unlikely Edits, and time length as specified in Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) code descriptions.

B. Component 2 (35% of total program value; up to $83.4 million) will be a uniform percent increase for the top 20 procedure codes from the Component 1 list, excluding crisis services, speech therapy services, and therapeutic activities, for the STAR/STAR+PLUS/STAR Kids programs. Component 2 is targeted to further incentivize the remaining uncertified CMHCs and LBHAs to obtain certification and CMHCs and LBHAs that obtained such certification to maintain it. Crisis services, speech therapy services, and therapeutic activities codes will be excluded as they are outside the CCBHC model. For Component 2, the uniform percent increase will be 54~~2~~.48~~19~~% for CMHCs and LBHAs without CCBHC certification status and 59.48~~47.19~~% for CMHCs and LBHAs who are CCBHC-certified. The uniform percent increase will be applied to the top 20 procedure codes. Certified CMHCs and LBHAs receive a higher percentage increase compared to non-certified CMHCs and LBHAs because the CCBHC model has additional costs related to providing whole-person care. Payments will be made as part of MCO processing the initial claim and thus will be based on SFY23 claims.

Please see Attachment D for Component 1 codes and associated units and Component 2 codes.

d. Describe how the increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract

The top 20 codes represent over 95% of adjusted SFY20 MCO claims for all CMHCs and LBHAs. Concentrating on the top 20 codes will make the payments easier to operationalize. As noted above in question 19c, for Component 2, crisis services, speech therapy services, and therapeutic activities codes will be excluded from the top 20 list because these codes are outside of the CCBHC model. The CCBHC cost-report rate methodology that establishes the Prospective Payment System(PPS)-2 rate is the CMS-approved methodology for payment for CCBHC services. Thus, the program targets to reimburse the participants working toward or maintaining CCBHC certification for the difference between the PPS-2 rates and MCO payments.

The integration of behavioral and physical health is a priority for Texas. In its 2018 annual report, the external quality review organization (EQRO) for Texas Medicaid reported that co-occurring Behavioral Health (BH)/Physical Health (PH) conditions accounted for the majority of potentially preventable events (PPEs) in STAR+PLUS. In the quarterly report published in December 2018, the EQRO noted that behavioral health providers had relatively lower PPE actual-to-expected (A/E) ratios compared to other providers. Promoting integration practices that focus on BH providers (e.g., encouraging BH providers to screen and monitor for chronic PH conditions) may further reduce PPEs among members with co-occurring conditions[i].

[i] https://hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/medicaid-chip-qei/ppe-co-occurring-conditions-exec-summary-2018.pdf